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Archives of Dermatology and Syphilology

VOLUME 9 JUNE, 1924 NUMBER 6

EPONYMS OF DERMATOLOGY*

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NEW YORK CITY

DEDICATED TO

GEORGE MILLER MACKEE

INTRODUCTION

"THE LIBRARY IS ALSO A LABORATORY"

All too often at clinical meetings and in dermatologic publications one finds references to a disease named after a person. Seldom does the speaker or writer give other than the eponym, and often then allows the hearer or reader a choice of disease, as more than one disease has at one time or another been accredited to an authority. In general, little is known regarding the man mentioned, and few would be able to give with accuracy any details as to the authority whose name is sounded.

Little is ordinarily known of the history of the disease, nor is it generally known that many are improperly accredited. This is entirely aside from the question of the propriety of naming diseases after people.

It occurred to me some time ago to make a study of eponyms in dermatology, and the search has been a most interesting one. In this section, I have considered for the most part diseases which bear the name of their discoverers.[1]

I have made every effort to confirm each reference given, but this has not been possible in every instance. Corrections and suggestions for the elaboration of this work will be properly accredited.

Acanthosis nigricans	Pollitzer
Acne cachecticorum	Hebra
Acne decalvans	Quincquad
Acnitis	Barthélemy
Actinomycosis	Rivalta
Acute circumscribed edema	Bannister

* Eponyms (eponymos, named after) the name of a disease, anatomic structure, operation, etc., derived from the name of the person who discovered or first described it.

1. I hope to enlarge on the subject by a consideration of eponyms as they deal with the anatomy, physiology, and pharmacology of the skin and its diseases, as well as to deal more completely with the eponyms of symptomatology.

Acute circumscribed edema	Quincke
Adiposis dolorosa	Dercum
Adrenal disease, etc.	Addison
Aleppo boil	Alibert
Alopecia areata	Bateman
Alopecia areata	Celsus
Alopecia universalis	Hippocrates
Anetoderma erythematosus	Jadassohn
Angina	Vincent
Angiokeratoma	Mibelli
Anthrax	Chabert
Blastomycosis	Gilchrist
Cancerous ulcer of leg	Marjolin
Chancre durum	Hunter
Cheilitis glandularis	Baelz
Cheilitis glandularis	Volkmann
Chimney sweep's cancer	Pott
Chondro dermatitis nodularis chronica helicis	Winkler
Chronic itchy disease of axillae, pubes, etc.	Fox-Fordyce
Chronic superficial excoriation of the tongue	Moeller
Circumscribed scleroderma	Addison
Colloid milium	Wagner
Congenital syphilitic abscess of thymus	Dubois
Dermatitis exfoliativa	Ritter
Dermatitis exfoliativa	Wilson
Dermatitis gangrenosa infantum	Hutchinson
Dermatitis herpetiformis	Duhring
Dermatitis papillaris capillitii	Kaposi
Dermatitis vegetans	Hallopeau
Ecbolic folliculitis	Grindon
Ecthyma	Bateman
Eczema marginatum	Baerensprung
Eczema seborrhoicum	Unna
Epidemic exfoliative dermatitis	Savill
Epidermolysis bullosa hereditaria	Goldscheider
Epidermolysis bullosa hereditaria	Köbner
Epithelioma adenoides cysticum	Brooke
Erysipeloid	Rosenback
Erythema elevatum diutinum	Bury
Erythema induratum	Bazin
Erythema infectiosum	Stickler
Erythema multiforme	Hebra
Erythema nodosum syphilitica	Mauriac
Erythema papuleux post erosif	Jacquet
Erythromelia	Pick
Erythrasma	Baerensprung
Erythrodermie pityriasique en plaques	Brocq
Erythromelalgia	Gerhard
Erythromelalgia	Weir-Mitchell
Fourth exanthem	Duke
Fourth exanthem	Filatov
Frambesia	Charlouis

General paresis	Bayle
Granuloma fungoides	Alibert
Granuloma fungoides	Auspitz
Granuloma leukemic	Bonfils
Granuloma leukemic	Hodgkin
Granuloma rubra nasi	Jadassohn
Herpes iris	Bateman
Hydradenitis destruens suppurativa	Pollitzer
Hydroa bulleux	Bazin
Hydroa herpetiformis	Tilbury Fox (Darier)
Hydroa puerperum	Unna
Hydroa vacciniformis	Bazin
Hydroa vacciniformis	Hutchinson
Hydrocystoma	Robinson
Ichthyosis	Wilson
Icterus gravis	Hippocrates
Icterus neonatorum	Buhl
Idiopathic multiple hemorrhagic sarcoma	Kaposi
Idiopathic progressive atrophy	Taylor
Impetigo contagiosa	Tilbury Fox
Impetigo herpetiformis	Hebra
Impetigo herpetiformis	Kaposi
Impetigo (staphylococcus)	Bockhart
Infective angioma	Hutchinson
Infectious eczematoid dermatitis	Engman
Infectious erythema	Hutinel
Keloid	Alibert
Keratosis follicularis	Darier
Keratosis follicularis	White
Keratosis follicularis contagiosa	Brooke
Kraurosis	Breisky
Leptothrix	Paxton
Lepra	Hansen
Lepra, anesthetic	Celsus
Lepra, anesthetic	Daneillsen
Lepra, nodular	Aretaeus
Lichen albus	Zumbusch
Lichen circumscriptus	Vidal
Lichen moniliformis	Kaposi
Lichen nitidus	Pinkus
Lichen obtusus	Unna
Lichen planus	Wilson
Lichen planus atrophicus et sclerosus	Hallopeau
Lichen urticatus	Bateman
Lupus erythematoides	Biett
Lupus erythematoides	Cazenave
Lupus marginatus	Hilliard (Hutchinson)
Lupus vulgaris	Willard
Lupus vulgaris	Hebra
Lupus vulgaris	Kaposi
Lupus vulgaris erythematoides	Leloir

Malignant papillary dermatitis	Paget
Mixed chancre	Rollett
Molluscum contagiosum	Bateman
Multiple benign tumor-like new growths	Schweninger-Buzzi
Myxedema	Gull
Neurofibroma	Recklingshausen
Notched upper incisors (congenital syphilis)	Hutchinson
Parakeratosis variegata	Unna-Politzer
Parapsoriasis	Brocq
Pediculosis corporis	Greenhow
Pemphigus foliaceus	Cazenave
Pemphigus vegetans	Neumann
Peculiar progressive pigmentary disease	Schamberg
Pityriasis rosea	Gibert
Pityriasis rubra aigu	Devergie
Pityriasis rubra	Hebra
Poikiloderma vascularis atrophicans	Jacobi
Porokeratosis	Mibelli
Precancerous dermatosis	Bowen
Prurigo ferox	Hebra
Prurigo mitis	Willan
Prurigo nodularis	Hyde
Pseudocolloid of lips	Fordyce
Psoriasis	Willan
Psoriasis (buccal)	Bazin
Psorospermose folliculaire vegetante	Darier
Psorospermose folliculaire vegetante	White
Purpura fulminans	Henoch
Purpura hemorrhagica	Werlhoff
Purpura rheumatica	Schoenlein
Purpura senilis	Bateman
Purpura telangiectoides annularis	Majocchi
Rare nodular disease of the hair	Giovanni
Reticulated atrophy	Zinsser
Rodent ulcer	Jacob
Sarcoid, multiple benign	Boeck (Caesar)
Sarcoid	Darier-Roussy
Scabies	Boeck (Carl Wilhelm)
Scleroderma neonatorum	Underwood
Sporothrix	Schenck
Symmetrical gangrene	Raynaud
Syringomyelia	Morvan
Tabetic arthropathy	Charcot
Tinea tonsurans	Gruby
Tinea versicolor	Eichstedt
Trichorrhexis nodosa	Beigel
Trichorrhexis nodosa	Hodara
Trophedema, chronic hereditary	Meige
Trophedema, chronic hereditary	Millroy
Ulerythema ophryogenes	Taenzer
Urticaria pigmentosa	Nettleship

Verruca necrogenica	Wilks
Verruga peruana	Carrion
Vitiligoidea	Addison-Gull
White spot	Westberg
Xanthoma	Rayer
Xeroderma pigmentosa	Kaposi
Yaws (?)	Breda

EPONYMS OF DISEASE

ADDISON'S DISEASE: *Diseased suprarenals with pigmentation, debility, and other system symptoms.*

Thomas Addison was born in England, April, 1793, and died on June 29, 1860. His birthplace was Newcastle on Tyne. He received his medical education at the University of Edinburgh, and graduated in 1815. His graduation thesis was on syphilis. Addison was house surgeon at the Lock Hospital and later was at Guy's Hospital.

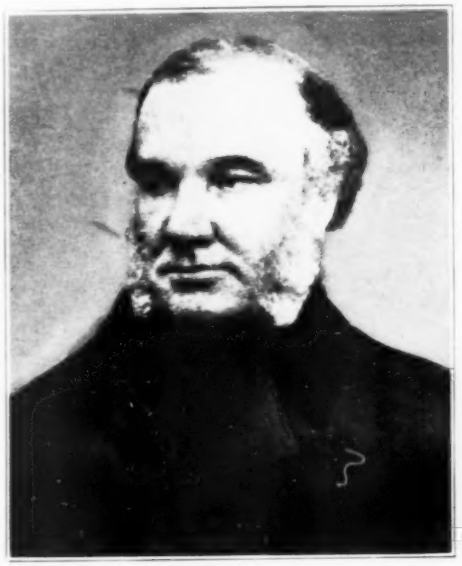

Fig. 1.—Thomas Addison (after Galerie hervorrangender Arzte).

He was a pupil of Bateman. "On the Constitutional Effects of Disease of the Suprarenal Capsules" by Addison was published in London in 1855. The book was regarded as a scientific curiosity in Addison's time, but is now considered an epoch-making contribution. A translation in German appeared in 1912. Although cases had been recorded as early as 1823 by Lobstein, and Schotte, and a third case by Richard Bright in 1829, it was the sagacity of Addison that detected the relation between the well marked constitutional symptoms of the condition, the peculiar pigmentation of the skin and the structural changes in the suprarenal capsules. Trousseau was the first to propose calling the suprarenal syndrome "Addison's disease."

ADDISON'S DISEASE: *Vitiligoidea, now known as xanthoma.*

Thomas Addison and William Gull described this condition, and one finds reference to it as Addison's disease. The article, "On a Certain Affection of the Skin, Vitiligoidea, (*a*) Plana, (*b*) Tuberosa," was published in *Guy's Hospital Reports* (7:265, 1851). These co-authors reported the first case of adenoma sebaceum.

ADDISON'S KELOID: *This condition is now known as morphea or circumscribed scleroderma.*

"A Collection of the Published Writings of the Late Thomas Addison, M.D., Physician to Guy's Hospital," was published by the New Sydenham Society (London, 1868).

ALIBERT'S DISEASE, also ALIBERT'S DERMATOSIS *Mycosis fungoides.*

Jean Louis Alibert was born at Villefranche de l'Avergron, France, on May 18, 1766. He studied medicine at Paris and graduated when 26 years of age. He was the author of several papers on fever, materia medica (*Mém. Soc. méd. d'emulat.* **1:** 180, 1797) and also some biographical sketches. He undertook the study of dermatology, and was the first to use the painter's palette and engraver's burin in the delineation of the diseases of the skin. Alibert was the founder of the French school of dermatology. He evolved the "natural method" ("Description des maladies de la peau," Paris, 1806) of classifying skin diseases. His twelve classes were divided as follows:

(*a*) Dermatoses eczemateuses: erythema, erysipelas, pemphigus, zoster.
(*b*) Derm. exanthemateuses: variola, vaccinia, varicella, roseola, rubeola, scarlatinia, miliara.
(*c*) Derm. dartreuses: herpes, varus, malitagra, esthimenos.
(*e*) Derm. cancereuses: carcinoma, keloid.
(*f*) Derm. lepreuses: leuce, spiloplaxis, elephantiasis, radesyge.
(*g*) Derm. veroleuses: syphilis mycosis.
(*h*) Derm. strumeuses: scrophula, malleus.
(*i*) Derm. scabieuses: scabies, prurigo.
(*j*) Derm. hemateuses: peliosis, petechiae.
(*k*) Derm. dyschromateuses: pannus, achroma.
(*l*) Derm. hetereomorphes: ichthyosis, tylosis, verruca, onychosis, dermatolysis, nevus.
(*m*) Derm. teigneuses: achor, porrigo, favus, trichoma.

Many new names were created by this system, which caused confusion in the nomenclature, and the classification was an arbitary one. Alibert's system preceded Willan's, which was yet unknown in France Alibert's system did not gain universal acceptance.

Alibert was the first to describe mycosis fungoides (pian fungoides) in "Description des maladies de la peau," etc. (1806, p. 157, Plate xxxvi). In 1832, he changed the name from pian to mycosis.

ALIBERT'S DISEASE: *Pustule d'Alep.*

Alibert is accredited with the description of pustule d'Alep, which is also called Alibert's disease. Russell, in 1756, and Peacocke, in 1845, described the disease as seen in Aleppo (Sur la pyrophlyctide endemique, *Rev. méd. franç. et étrang., Paris* **3:** 62-71, 1828).

ALIBERT'S KELOID *Cheloid (cancroid) 1810; keloid; kelis, 1835.*

This disease also has Alibert's name attached to it. Our reference is *Monogr. d. dermat.*, Paris, Ed. 2, **2:** 195-212, 1835; also Alibert's

Fig. 2.—Jean Louis Alibert (after Galerie hervorrangender Arzte).

Atlas, Plates xxviii and xxix. In the first edition, the disease was called cancroid; later cheloid.

MENTAGRA OF ALIBERT: *Sycosis of beard.*

Pliny (32 A.D.) described a mentagra, but not synonymous with that of Alibert.

Alibert made many studies in therapeutics, especially that of sulphur. He also investigated the histology of the pustules of variola. Biett, a pupil of Alibert, founded the St. Louis School. A "Precis theorique et pratique sur les maladies de la peau" was published in 1818; and a "Monographie des dermatoses" in 1842. His text was translated into

Italian and German. He also published an atlas of which there was an Italian and an English edition.

Alibert, who received the title of baron, died on Nov. 4, 1837.

ARETAEI ELEPHANTIASIS: *Nodular leprosy.*

Aretaeus was born in Cappadocia about the second half of the first century, A.D. (30 to 90 A.D.). He lived toward the close of the reign of Nero. He is known to have resided in Alexandria. Aretaeus was a good clinician and an attractive medical author. He described symptoms accurately, and the descriptions are easily recognized. His treatment for leprosy was classical. Much interesting information concerning Aretaeus the Cappadocian, also considered the

Fig. 3.—Aretaeus (after Chronol. Med.).

Lost Physician, may be gleaned from consulting the *Johns Hopkins Hospital Bulletin* (**20:** 371-377, 1909); also the chapter in Robinson's "Pathfinders of Medicine," beginning on page 35.

AUSPITZ'S DERMATOSIS: *Granuloma fungoides.*

Heinrich Auspitz was born at Nikolsburg in Mähren, Austria, 1835. He was a pupil of Brücke, Rokitansky, Skoda, Appolzer and Hebra. The disease which is often linked with his name (Auspitz' granuloma fungoides, *Viertelj. Dermat. u. Syph.* **12:** 123, 1885) was first described by Alibert in 1806. Kaposi described the same disease as "syphilis vegetans" in 1869. Auspitz studiously investigated the pathology of skin diseases (*Arch. f. Dermat. u. Syph.* **2:** 54, 1870) and applied the name "parakeratosis" to the scaly condition of the skin as it occurs in psoriasis. He also named "acanthoma" as benign epidermal tumors. The formation of vesicles and the bullae of pemphigus were also studied. We are also indebted to Auspitz for the sign in psoriasis named after

him "Auspitz's sign": the bleeding points disclosed by removing the scale. Auspitz published a text in Paris in 1887. His classification of skin diseases was illuminating (System der Hautkrankheiten, Wien, 1881), and was based on the pathogenesis of the diseases. An analysis appeared in the *Journal of Cutaneous Diseases* (**2:** 161 and 202, 1884). Auspitz died on May 23, 1886.

BAELZ'S DISEASE: *Cheilitis glandularis; myxadenitis labialis.*

Erwin B. Baelz was born in Germany in 1845. He studied at Stuttgart, and was called to the medical school at Tokio in 1875. He made numerous studies of the parasites of Japan and revealed many as the cause of disease, including that of parasitic hemoptysis (paragonomiasis) 1880. Baelz reported a study on the effects of sun rays

Fig. 4.—Heinrich Auspitz (after Pagel).

on different races and on pigment formation (*Verhandl. d. Berlin Gesellsch. f. Anthrop.* 1901, pp. 204 and 245).

Baelz died in 1913 (*J. A. M. A.* **61:** 1055, 1913).

BAERENSPRUNG'S DISEASE: *Eczema marginatum circumscriptum femorale.*

Friederick William Felix von Baerensprung was born in Berlin on March 30, 1822. His dissertation at graduation in 1848 was on the "Anatomy and Pathology of the Human Skin." He was an early exponent of the study of dermatology in Germany, and one of its nineteenth century leaders. Baerensprung made many original microscopic studies, especially in the parasitology of skin diseases. He advanced the idea of an anatomic foundation in the spinal ganglion as the cause of herpes zoster (1861-1863). He considered intra-uterine affection of the spinal ganglion as the cause of linear arrangement of nevi following the course of cutaneous nerves (*Charité-Ann.* **11:** 2, 1863). His studies included pemphigus, xanthoma, prurigo and onychomycosis. He believed that molluscum was a contagious disease. Baerensprung proposed the "dual theory" for concomitant infection of

soft and hard chancre to account for the induration in the former, and was an opponent of the "unitarian" idea (Proksch: *Gesellsch. der ven, Krankh.*, Bonn **2:** 274, 1895).

Baerensprung's system of skin diseases was founded on physiologic grounds:

I. Disturbances of Innervation: (*a*) derangement of sensibility (pruritus), (*b*) motor disturbances, (*c*) local derangements.

II. Derangements of Secretion: seborrhea, hyperhidrosis and anhidrosis.

III. Derangement of Nutrition: (*a*) emphysema cutaneum, (*b*) edema cutaneum, (*c*) hyperemia and anemia, (*d*) hemorrhages, (*e*) inflammations: (1) diffuse: (*a*) erythematous; (*b*) phlegmonous; (*c*) eczematous; (2) exanthematic; (3) furunculosis; (*f*) ulcers: (1) idiopathic, (2) malignant, (3) dyscrasic; (*g*) gangrene, (*h*) pigment formation, (*i*) hypertrophy; (1) epidermal hypertrophy, (2) papillary hypertrophy, (3) vascular hypertrophy, (4) hypertrophy of the corium, (5) hypertrophy of the hair follicles and cutaneous glands; (*k*) carcinoma: (*l*) morbid conditions of the hairs, (*m*) morbid conditions of the nails.

BAERENSPRUNG'S ERYTHRASMA.

This condition was first described by Burchardt in 1859 (*Med. Zeitung*, p. 141). Baerensprung discovered *Microsporon minutissimum* of erythrasma in 1862. The article appeared in *Charité-Annalen* (**6:** 150, 1862).

Baerensprung died of dementia paralytica on Aug. 26, 1864.

BANNISTER'S DISEASE: *Edema angioneuroticum.*

Henry Martyn Bannister was born on July 25, 1844. He was graduated from the National Medical College of Washington, D. C., in 1871. He was on the Geological Survey of the territories, including Alaska. He practiced in Chicago. He was the first to report angioneurotic edema in the *Journal of Nervous and Mental Diseases* (**2:** 627-631, 1894). Bannister was co-author of a "Practical Manual of Mental Medicine." He was editor of the *Chicago Journal of Nervous and Mental Diseases;* and a member of the editorial staff of the *Journal of the American Medical Association.* He died on May 1, 1920.

BARTHÉLEMY'S DISEASE: *Acnitis; papular necrotic tuberculid.*

P. Toussaint Barthélemy was born in 1850. He was a French dermatologist. He wrote his paper on acnitis in the *Annales de dermatologie et de syphiligraphie* (**2:** 1, 1891; **8:** 173, 1897). This disease was first described by Tilbury Fox in 1878, who regarded it as disseminated follicular lupus (*Lancet*, July 13-20, 1878, pp. 35 and 75). As acne nodulaire, Barthélemy had described a case in the *Annales* of 1881. A paper on acnitis and folliculitis appeared in the *Bulletin de la Société française de dermatologie et de syphiligraphie* (**1:** 261, 1890).

Crocker accredited Barthélemy with naming folliclis. Barthélemy was the author of "Étude sur le dermagraphisme ou dermoneurose toxivasomotrice," Paris, 1893. This was an excellent illustrated monograph of the literature, cases and a history of the disease in the middle ages when pseudomiracles were worked on the patients by priests.

Barthélemy reported the swelling of neighboring glands in herpes zoster in the *Annales* (**2**: 21, 1891; **3**: 168, 1892).

BATEMAN'S DISEASE: *Molluscum contagiosum.*

Thomas Bateman was born in Whitby, England, on April 29, 1778. He was a student of Robert Willan, who has been accredited with having been the father of modern English dermatology. Bateman studied in London and Edinburgh. His thesis was on the subject of petechial hemorrhages. Molluscum contagiosum is not the only disease accredited to Bateman, as will be seen by consulting the list which follows.

BATEMAN'S DISEASE: *Purpura senilis.*

Bateman distinguished this type of hemorrhagic spots (Bateman's Atlas, 1828, Plate xxx; De haemorrhoea petechiale, 1801) which occur incessantly for years without general disturbance, in the aged, predominantly on the forearms. These are related to senile degeneration of the skin.

BATEMAN'S DISEASE: *Alopecia areata.*

Occasionally one finds this eponym in the literature.

BATEMAN'S ECTHYMA.

Bateman is accredited with the first description of this disease.

BATEMAN'S DISEASE: *Lichen urticatus.*

This disease was also first described by Bateman.

BATEMAN'S DISEASE; BATEMAN'S HERPES: *Herpes iris.*

This manifestation is accredited to Bateman. The type is rare, as around a central bulla one finds a ring of vesicles (Bateman's Atlas, Plate lii).

Bateman knew cheilitis exfoliativa as "psoriasis labialis."

Bateman was a worthy successor to Willan, and not only completed, but amplified the teachings of the senior in "Delineations of Cutaneous Disease" by Willan and Bateman (London, 1817, 1840 and 1849). There was an earlier work by Bateman, "A Practical Synopsis of Cutaneous Disease According to the Arrangement of Dr. Willan," 1813. This ran into several English editions as well as a French translation and

three German ones; a Swedish translation appeared and an American edition.

Bateman died on April 9, 1821 (Some Account of the Life and Character of the Late Thomas Bateman, London, 1826).

BAYLE'S DISEASE: *General paresis.*

Antoine Laurent Jesse Bayle was born in Vernet, France, 1799. He was a distinguished physician with an extraordinary knowledge of pathology. He was responsible for numerous monographs as well as reports of researches. The thesis by which his name has come to us was, "Recherches sur les maladies mentales" submitted to the faculty of medicine at Paris, 1822. Bayle died at Paris in 1858 Centenaire de la Thesis de Bayle, 1822-1922 (Paris, 1922).

BAZIN'S DISEASE: *Erythema induratum.*

Antoine Pierre Ernst Bazin was born at Saint Brice, France, on Feb. 20, 1807. He was the son of a physician of a family of physicians. He studied at Paris and received his medical diploma in 1834. He was a Gold Medal scholar in 1832. He became attached to the Hospital St. Louis in 1847. He made many studies on the parasitic causation of the tineas (Recherches sur la nature et le traitement des teignes, 1853). He described the animal to man transference of these organisms. He investigated the etiology of scabies and its treatment, 1851. He gave the first clear account of mycosis fungoides, 1862. He described acne varioliformis or pilaris in 1851, and is said to have been the first to describe acne keloid. Bazin is also said to have been the first to describe hydroa vacciniforme, which later became Hutchinson's "summer eruption." A type of erythema induratum, different from the type described by Bazin is also accredited to Hutchinson. Bazin's type, "erythema indure des scrofuleux," is described in "Leçons sur la scrofule" (Paris, 1861, pp. 145 and 501). Bazin was the author of "Affect. Cutan. Arthrit et Dartreuses" (Paris, 1868).

Bazin had a great influence on French dermatology. He presented the following classification: (1) deformities: nevi, vitiligo; (2) surgical: (*a*) mechanical, as wounds; (*b*) artificial, from parasites; (3) internal diseases: exanthems, etc.; (4) pseudo-exanthems: phlegmasiae, purpura, herpes and diatheses.

Bazin brought order out of chaos in the field of parasitology in dermatology, and published "Leçons theoriques et cliniques sur les affections cutanées parasitaires" in 1858, and other texts in 1860 and 1865.

Bazin has been accredited also with "hydroa" identical with Bateman's "herpes iris" and with hydroa bulleux, a rare form of dermatitis herpetiformis.

BAZIN'S DISEASE: *Buccal psoriasis.*

Reference to this eponym has been found.

Bazin died on Dec. 14, 1878.

BEIGEL'S DISEASE: *Trichorrhexis nodosa.*

Herman Beigel was born in Germany, 1830, and was educated in Vienna and England. He was physician at the Metropolitan Free Hospital, and lecturer on skin diseases at Charing Cross Hospital. He devoted considerable study to the hair and its development, as well as to general subjects, especially gynecology. Among his literary works may be mentioned, "Atlas der Frauenkrankheiten," 1876; "Handbuch für Gynäkologie," and "The Human Hair," 1869. He published a paper describing his observations on trichorrhexis nodosa (*Deutschr. d. Wien. kais. Akad. d. Wissen.* **17:** 612, 1885). Wilson is said to have been

Fig. 5.—Herman Beigle (after Pagel).

the first to describe this disease, 1849. Another paper, "Ueber Auftreibung und Bersten d. Haar" was published in the *Sitzungsbericht d. Mathem. Naturw. Klasse d. Wien*, 1855. Beigel also described chignon fungus (Diseases of the Hair, p. 11) caused by *Sclerotium beigelanum* (Hallier). Beigel wrote a paper on "Eine bisher nicht beschriebene Hautkrankheit (Papilloma area-elevatum) (*Arch. f. path. Anat.* **47:** 7, 1869).

Beigel died in 1879.

BIETT'S DISEASE: *Lupus erythematoides migrans, or erythema centrifugum.*

Laurent Theodor Biett was born in 1781. He was a pupil of Alibert in Paris; and had also gone to England to become a pupil of Willan and Bateman. Biett published little in the ordinary way, but a record of his experiences was published by Cazenave and Scheidel. Biett was interested in lupus, and began the treatment of chronic skin diseases with arsenic.

COLLAR OF BIETT.

This is the name given to a manifestation of papular syphilis in which a fine scale readily detached from the center persists at the periphery and forms a fringe.

The publication of "Pratique des maladies de la peau" (Paris, 1828) bears Biett's name.

Biett died on March 3, 1840.

BOCKHART'S IMPETIGO: *Staphylococcic impetigo.*

Max Bockhart was a German dermatologist of the nineteenth century. He separated the follicular type of impetigo which bears his name from the contagious impetigo of Tilbury Fox. His paper, "Ueber die Aetiology und Therapie der Impetigo," etc., was published in

Fig. 6.—Caesar Boeck (after Norsk Mag. f. Lægevidensk.).

Monatshefte für praktische Dermatologie (**6:** 450, 1887). Bockhart asserted that the lesions were pustules from the first (pustule d'emblée). Bockhart also sought a microbic origin for eczema. Bockhart also wrote, "Ueber die Beziehungen zwischen Scrofulose und Syphilis" (Wurzberg, 1881).

Unna wrote a paper on "Impetigo Bockhart" (Berl. Klin. **46:** 1, 1892).

BOECK'S SARCOID: *Multiple benign sarcoid of Boeck.*

Caesar P. M. Boeck was born in 1845 and died in 1917. He was a prominent dermatologist recognized both in his own country and abroad. He was an honorary member of the American Dermatological Association. The article on the disease most often associated with Caesar Boeck's name is: "Multipelt benignt hudsarcoid" (*Norsk. Mag. f. Laegevidensk.* **4:** R. 14, 1321-1334, 1899, 4 plates). Caesar Boeck described the exanthems of tuberculosis (in 1898) to which Darier

gave the name of tuberculids. Acne necrotica is likewise accredited to Boeck (*Arch. f. Dermat.* 1899). Papers on "The Nature of Lupus Erythematosus," and on "Benign Sarcoid" were published in translation by the New Sydenham Society, 1900, pp. 286 and 306.

BOECK'S DISEASE: *Scabies.*

Carl Wilhelm Boeck was born in Norway in 1808. He died in 1875. Carl Boeck's first published paper was "Om den Spedalskhed Sygdom, Elephantiasis Graecorum" (Christiana, 1842). He made special studies in syphilis and syphilis in children. The references we have are: Traite de la radesyge, syphilis tertiare, 1860; Erfahrungen om Syphilis, 1875, also translated into German; Syphilis von Kindern, 1856; also 1871; Spedalskhed, 1871; and Fistula vesico-vaginalis, 1875.

Fig. 7.—Carl Wilhelm Boeck (after Lepra).

BOWEN'S DERMATOSIS: *Precancerous dermatosis.*

John Templeton Bowen was born on July 8, 1857. He is a dermatological practitioner in Boston. He is a member of the American Dermatological Association and was its president, 1902 to 1903. The cancerous dermatosis with which Bowen's name is associated was first described in the *Journal of Cutaneous Diseases* (**30:** 241, 1912; **33:** 787, 1915). Darier has confirmed the peculiarity of this affection. Bowen has made clinical, bacteriologic and blood examinations, including necropsy reports of a series of cases on dermatitis exfoliativa (*J. Cutan. Dis.* **28:** 1, 1910). He also reported a severe and persistent example of Hebra's type of pityriasis rubra in *St. Paul's Medical Journal* (**2**: 91, 1900). He has a good review of the literature on hydroa vacciniforme (*J. Cutan. Dis.* **2:** 89, 1894). Bowen described a combination of purpura and angioneurotic edema (*J. Cutan. Dis.* **10:** 434, 1892). He pub-

lished, "The Epitrichial Layer of the Human Epidermis" (*Anat. Anz.*, Jena **4:** 412, 1889).

BREDA'S DISEASE: *Brazilian yaws (?)*

Achille Breda, an Italian, reported the demonstration of a bacillus in frambesia Brasiliana, or boubas (*Arch. f. Dermat. u. Syph.* **33:** 3, 1895). A translation of this was published in the New Sydenham Library, in the volume for 1897. Breda published "Manuale pratico de malattie veneree e sifiliche" in 1887.

BREISKY'S DISEASE: *Kraurosis vulvae.*

August Breisky was born at Klattau, Bohemia, on March 25, 1832. He studied in Prague, and was much interested in the specialties of gynecology and obstetrics. His first important work was "Influence of Kyphosis on the Formation of the Pelvis," 1865. He wrote an article on "Die Krankheiten der Vagina" for Pitha and Billroth's "Chirugie," published at Stuttgart, 1879, and in translation by William Wood & Company, New York, in 1887, as part of the "Encyclopedia of Obstetrics and Gynecology."

Weir and Tait had recorded cases of kraurosis vulvae prior to Breisky, but they did not appreciate the nature of the disease. Breisky's paper appeared in the *Zeitschrift für Heilkunde*, 1885, p. 69.

Breisky died on May 25, 1889.

Kleinwachter wrote "Errinnerungen an August Breisky" for *Janus* **9:** 433, 1904.

BROCQ'S DISEASE: *Parakeratosis psoriasiforme; parapsoriasis.*

Anne Jean Louis Brocq was born in France, 1856. The paper on "Les Parapsoriasis" was published in *Annals de dermatologie et de syphiligraphie* **3:** 313, 1902. Brocq is the author also of "L'acne excoriée des jeunes filles" (Paris, 1898). He also described pseudopelade, pruritus with lichenification and lupus sycosis. He wrote, "Notes pour servir a l'histoire de la keratose pilare" in the *Annales* of 1890; also, "De la dermatit herpetiforme de Duhring" (*Ann. de dermat.* **9:** 1, 1888) as well as "De la destruction des poils par l'electrolyse" (*Bull. et mém. Soc. méd. d. hôp. de Paris* **3:** 3, 1886). In 1921, Doin of Paris published Brocq's "Precis atlas de pratique dermatologique."

Brocq is a corresponding member of the American Dermatological Association.

BROOKE'S DISEASE: *Epithelioma adenoides cysticum.*

Henry Ambrose Grundy Brooke was born in 1854. He received his professional education at Owen's College and Guy's Hospital. He studied at Vienna and Paris, under Kaposi, Besnier and Unna. He

founded the Manchester and Salford Hospital for Skin Diseases. He wrote on psoriasis, lichen and other dermatologic subjects. He had intended to write a book, but he suffered an attack of hemiplegia in 1906.

The disease which bears Brooke's name was described in the *British Journal of Dermatology* (**4:** 269, 1892). There is a consideration of the subject by Perry in the "International Atlas," Part 3, Plate 9. Brooke also described erythema keratoides (*Brit. J. Dermat.* **3:** 335, 1891). He suggested vessel changes as the cause of psoriasis (Albutt's System **8:** 560, 1899). He described the least common form of seborrhea psoriasiformis (*Brit. J. Dermat.* **1:** 247, 1889).

BROOKE'S DISEASE: *Keratosis follicularis contagiosa.*

This disease also has Brooke's name. It was described in the "International Atlas," 1892, No. 7, Plate xxii. Brooke claimed as previous examples of this rare disease: acne sebacée cornée (Cazenave); acne cornée (Leloir and Vidal); ichthyosis follicularis (Lesser) and keratosis follicularis (Morrow).

Brooke died in 1919.

BUHL'S DISEASE: *Icterus neonatorum.*

Ludwig von Buhl was born in Germany on Jan. 4, 1816. He died on July 30, 1880. Buhl was a student of pathology and was distinguished as a master of physical diagnosis. He differentiated three types of puerperal fever. He was the author of "Lungenentzündung, Tuberculose, und Schwindsucht," 1873.

BURY'S DISEASE: *Erythema elevatum diutinum.*

Judson Sykes Bury published a paper on "A Case of Erythema with Remarkable Nodular Thickening of the Skin Associated with Intermittent Albuminuria" (*Illustrated Med. News*, London **3:** 145, 1888). This disease was first described by Middleton (*Am. J. M. Sc.*, October, 1887). The name was given by Williams and Crocker (*Brit. J. Dermat.* **6:** 1, 144 and 148, 1894). Further notices appeared in the *Illustrated Medical News*, on Feb. 23, 1889; and in *Clinical Medicine*, 1912. Graham Little and Stelwagon considered this disease as belonging to the domain of granuloma annulare.

Bury wrote several treatises on the diseases of the nervous system, as well as a manual of clinical medicine.

CARRION'S DISEASE: *Verruga peruanna.*

Daniel A. Carrion, a medical student of Peru, inoculated himself experimentally with this disease, and died as the result in 1886 (*Monit. Med. Lima* **3:** 145, 1887-1888; *Cron. Med. Lima* **15:** 335, 1898).

CAZENAVE'S DISEASE: *Lupus erythematoides*

P. L. Alphée Cazenave was born in Paris, 1795. He died in April, 1877. He early became interested in diseases of the skin, and indeed this broad subject was the title of his thesis. Cazenave was a student of Biett (1781-1840), who had taken to France from England the doctrines of Willan and Bateman. In Cazenave and Schedel's "Pratique des Maladies de la Peau," 1828, Cazenave followed Willan's system, but included the therapeutics of Biett. The text was published in translation in Germany, England and America. Cazenave, in 1838, applied the name of facial impetigo or "impetigo en masque" to porrigo larvalis —from larva, a mask (*Ann. des mal. de la peau* **3:** 298, 1851).

CAZENAVE'S DISEASE: *Pemphigus foliaceus (1844)*

Cazenave gave the original description of this disease (Nikolsky: "Contribution a la question du pemphigus foliace de Cazenave, These de Doctorat," Kief, 1896).

Cazenave also wrote a compendium on diseases of the skin and syphilis and diseases of the hair, as well as a manual, which were edited in England.

AREA CELSI: *Alopecia areata.*

Aurelius Cornelius Celsus was born 53 B. C. and died 7 A. D. This was about the time of the reign of Tiberus Caeser. Celsus was a general student and not a physician. His knowledge of medicine was practically complete for the time, and his writings are the oldest medical documents after those of Hippocrates. Many advances in dermatology are recorded in the script of Celsus as compared with the work of Hippocrates. In the Sixth Book, Celsus deals with the diseases of the skin and the venereal diseases. About forty skin diseases are described, and alopecia areata is still known as area Celsi. The descriptions of alopecia are especially well done, and Celsus differentiated the types of alopecia, including the ophiasis type of alopecia areata. One may recognize under other designations or groupings: erythema multiforme, "rheumatic affection," furuncle, carbuncle, anthrax, tuberculous ulcer, bubo, condyloma acuminatum, verruca vulgaris and clavus. The bullous diseases, such as miliaria, vesicular eczema, dermatitis venenata, dermatitis calorica and dermatitis congelationes are recognizable, as well as acne, psoriasis, ichthyosis, herpes tonsurans and scabies. The single diseases, such as carbuncle, anthrax, etc., were made the subject of special studies. Of the venereal diseases, only the local conditions were known, as ulcus molle, genital abscess, condylomata acuminata, phimosis, etc.

VITILIGO CELSI: *Anesthetic leprosy (the last a word never used by Celsus).*

KERION CELSI: *Trichophytosis.*

An English translation, "The Eight Books on Medicine by Celsus," by J. W. Underwood, was published in London in 1842. Erasmus Wilson wrote a paper on "Dermato-pathology of Celsus" (*Brit. M. J.* **2:** 446 and 465, 1863).

CHABERT'S DISEASE: *Symptomatic anthrax.*

Philibert Chabert was born at Lyon, France, Jan. 6, 1737. He studied animal diseases and was general inspector of veterinary schools. He was probably the most celebrated veterinarian of his time. Oleum

Fig. 8.—Aurelius Cornelius Celsus (after the Collection of the Academy of Medicine, New York).

contra taeniam, Chaberti, was named after him. This drug is also used in the treatment of human tapeworm. Chabert published "Traite du charbon ou anthrax dans les animaux" in 1782; "Traite des maladies vermineuses dans les animaux" in 1783; and "Maladies des animaux domestiques" in 1812.

Chabert died on Sept. 8, 1814.

CHARCOT'S JOINT: *Tabetic arthropathy.*

Jean-Marie Charcot was born in Paris, on Nov. 29, 1825. His inclination was to study art while still a youth, but lack of funds determined him to study medicine. As a physician he made special studies in chronic diseases and those of old age (geriatrics). He

studied pathologic anatomy, and he was professor of pathologic anatomy of the Faculty of Medicine at Paris, succeeding Vulpian. He was an early exponent of the use of electricity in medicine as a therapeutic agent. He described gastric crises in locomotor ataxia (with George Delamarre) in 1886. He wrote a paper on skin diseases dependent on the influence of the nervous system (*Jour. de la physiol. de l'homme* **2:** 108, 1859). Charcot was appointed professor of nervous diseases, a chair having been founded especially for him.

Charcot died on Aug. 16, 1893.

Fig. 9.—Jean-Marie Charcot (after Garrison).

CHARLOUIS' DISEASE: *Frambesia tropica.*

M. Charlouis published a paper on "Ueber Polypapilloma Tropicum (Frambesia)" (*Viertelj. f. Dermat.* **8:** 431, 1881). This report has been translated (*New Sydenham Soc.*, 1897, pp. 287-319).

DANIELLSEN'S DISEASE: *Daniellsen-Boeck disease; anesthetic leprosy.*

Daniel Cornelius Daniellsen was born in Norway on July 4, 1815. He was a pharmacist. He was tuberculous and bedridden for several years. Despite this, he later studied medicine. He was co-worker and co-author with Boeck on their classical studies of leprosy. They wrote, "On Spedalskhed with an Atlas;" also "Traite de la Spedalskhed, "Paris, 1848, two volumes. They also wrote "Vegetable Parasitical Disease of the Skin with an Atlas," 1892; and "Recueil d'observations sur des maladies de la peau (French and Norwegian text).

Daniellsen had many interests other than medicine, such as the theater and biology.

Daniellsen died in 1894.

DARIER'S DISEASE: *Psorospermosis; keratosis follicularis (1889).*

J. Darier was born in Budapest, Hungary, of French parents, on April 26, 1856. He is one of the foremost dermatologists of France. He is an honorary member of the American Dermatological Association and the author of a textbook which has gone through several French editions and one each in German and English. The disease which bears his name is said to have been first described by Morrow (*J. Cutan. Dis.* **4:** 257, 1886), and Lutz and White are said to have given clear descriptions. The paper by Darier and Thibault may be found "De la psorospermose folliculaire vegetant" (*Ann. de dermat.* **10:** 597, 1889; *Thesis*

Fig. 10.—Daniel Cornelius Danielsen (after Lepra).

de Paris, 1889). Darier had also described pseudoxanthoma elasticum before the Third International Dermatological Congress in 1896. Darier made a study of vesicles and divided them into two classes—the interstitial and the parenchymatous. He made a classification of the carcinomas on an anatomic basis. Darier associated an eosinophilia with Duhring's disease (*Soc. franç. de dermat. et de syph.,* 1896).

With Roussy, Darier described hypodermic sarcoid (*Arch. de med. exper. et anat. path.* **18:** 1, 1906; *Bull. Soc. franç. de dermat.* **15:** 54, 1904; *Ann. de dermat.* **5:** 144, 1904).

Darier wrote on the parasitic nature of dyshidrosis (*Lancet* **2:** 578, 1919).

DERCUM'S DISEASE: *Adiposis dolorosa.*

Francis Xavier Dercum was born in Philadelphia, on Aug. 10, 1856. He is a prominent neurologist in his native city, Philadelphia, and professor of nervous and mental diseases. The paper of the original description of the disease named for him may be found, "A Subcutaneous Connective Tissue Dystrophy of the Arms and Back Associated with Symptoms Resembling Myxedema" (*University M. Mag.* **1,** No. 150 [Dec.] 1888-1889. "Three Cases of a Heretofore Unclassified Affection Resembling in Its Grosser Features Obesity, but Associated with Special Nervous Symptoms—Adiposis dolorosa" (*Am. J. Med. Sc.* **104:** 521, 1892).

Dercum has contributed numerous articles on nervous diseases, as well as a textbook.

Fig. 11.—Marie G. A. Devergie (after Clinique de la Mal. Syph.).

DEVERGIE'S DISEASE: *Pityriasis rubra pilaris.*

Marie Guillaume Alphonse Devergie was born in France, on Feb. 15, 1798. The disease named after him had a remarkable history in that Hebra described a lichen rubra, and as a further complication, Kaposi described a lichen ruber acuminatum. At the Dermatological Congresses of 1882 and 1884, it was finally conceded that the three diseases were identical. Devergie's description of the disease bearing his name may be found on page 454 of his book "Traite pratique des maladies de la peau," 1857. This volume opened the field of etiology in dermatology. Devergie discussed the etiology of skin diseases as climatic, hereditary, temperamental, according to age and skin constitution. He devised a dermatologic system based on pathologic anatomy, but it had no special advantages. Devergie was a codescriber with Baerensprung

of eczema marginatum. Devergie also wrote a book on "Legal Medicine," which ran through three editions.

Devergie died on Oct. 2, 1879.

DUBOIS' DISEASE: *Congenital syphilitic abscess of the thymus.*

Paul Antoine Dubois was born in France in 1795. He died in 1871. He was the son of a physician. He was especially interested in obstetrics. He published numerous articles and a complete treatise on obstetrics (Paris, 1849).

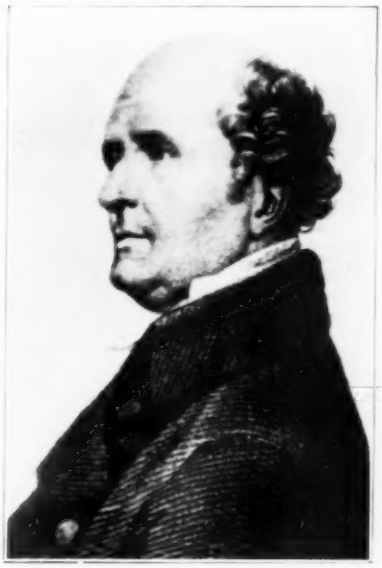

Fig. 12.—Paul Antoine Dubois (after Collection Library of Physicians and Surgeons, New York).

DUHRING'S DISEASE: *Dermatitis herpetiformis.*

Louis Adolphus Duhring was born in Philadelphia, on Dec. 23, 1845. He studied in this country, and in Europe at London, Paris and Vienna. He was early identified with American dermatology. Duhring was a founder and the second president of the American Dermatological Association. Although it is said that Bazin foreshadowed it and that Tilbury Fox gave the first description (*Am. Arch. Dermat.* **6:** 16, 1880, a posthumous paper edited by Colcott Fox) of the disease which bears Duhring's name, it is generally conceded that the American dermatologist deserved the credit for its clear elucidation and proper grouping (*J. A. M. A.* **2:** 225, 1884). Duhring wrote the first American textbook on dermatology, 1877, entitled "Practical Treatise on Skin Diseases."

This has been translated into French, Italian and Russian. An Atlas on Skin Diseases was published in 1876. The New Sydenham Society published many of Duhring's papers in 1893, pp. 179 to 297. Duhring classified diseases of the skin on a scheme which was modified from Hebra's system (A Practical Treatise on Diseases of the Skin, Philadelphia, 1877, 1881 and 1882), although his later modifications were too extreme for general acceptance (*J. Cutan. Dis.* **16:** 97, 1898). Duhring reported the first case of granuloma fungoides in America (*Arch. Dermat.*, 1879, p. 1). He first described dermatitis hiemalis (*Phil. Med. Times* **4:** 3, 1873).

Duhring died on May 8, 1913, after an illness of two months.

Fig. 13.—Louis Adolphus Duhring (after American Dermatological Association portraits).

EICHSTEDT'S DISEASE: *Tinea versicolor.*

Karl Ferdinand Eichstedt was born in Germany, on Sept. 17, 1816. He established the relation between pityriasis versicolor and *Microsporon furfur* and published an article on the subject (*Neue Notizen a. d. Geb. d. Nat. u. Heilk.* **38:** 105, 1846; **39:** 265, 1 plate). The parasite was christened by C. Robin.

Eichstedt died in 1892.

ENGMAN'S DISEASE: *Infectious eczematoid dermatitis.*

Martin Feeney Engman was born in New Orleans, in 1868. He is a well-known dermatologist in St. Louis, where he is clinical professor of dermatology in the Washington University Medical School, and senior dermatologist of the Barnard Free Skin and Cancer Hospital, which he founded. He is a member of the American Dermatological Association, and was its president, 1919 to 1920. He described the disease which bears his name in a paper on "Dermatitis infectiosa eczematoides" (*Am. Med.* **4:** 769, 1902). Engman also made a report on lichen

planus annularis (*J. Cutan. Dis.* **19:** 209, 1901). He also made an interesting record of a "Psoriasis Tree" (*J. Cutan. Dis.* **31:** 559, 1913) as well as a study of "The Pathogenesis of Placental Syphilis" (*J. A. M. A.* **58:** 1415, 1912). Many other papers have been published with Mook as co-author. Engman and Mook also have a valuable collection of clinical photographs of dermatologic interest.

FILATOV'S DISEASE: *Duke's disease; fourth exanthem.*

Nil Feodowitsch Filatov, a Russian interested in pediatrics, was born in 1847. He has often been acclaimed as the first describer of the spots in the mouth to which the name of Koplic has been attached (*Med. Mod.* **6:** Suppl. 617, 1895). Filatov was the author of a text on diseases of children which was translated from the original into German, French, English and Italian.

FORDYCE'S DISEASE: *Pseudocolloid of the lips.*

John Addison Fordyce was born in the United States, on Feb. 16, 1858. He is one of the most distinguished dermatologists in the country, and was professor of dermatology and syphilology at New York University and Bellevue Hospital Medical College, and is now at Columbia University. He is a member of the American Dermatological Association, and was its president from 1898 to 1899. The condition to which his name has been linked was described as, "A Peculiar Affection of the Mucous Membrane of the Lips and Oral Cavity" (*J. Cutan. Dis.* **14:** 413, 1896). Fordyce was the codescriber with George Henry Fox of the disease which bears both their names. He reported further on this condition before the American Dermatological Association, 1918 (trans. p. 118). Fordyce demonstrated an unusual case of lichen planus limited to the penis and mucous membrane of the cheek (*J. Cutan. Dis.* **28:**57, 1910). He reported, "Infectious Eczematoid Dermatitis; Possible Influences of Anaphylaxis Reactions" (*J. Cutan. Dis.* **29:** 129, 1911). Fordyce reported numerous cases of dermatologic interest, with especial reference to the histopathologic aspect

Fordyce made many original investigations in the pathology of syphilis, especially vessel changes. One owes to him, too, a great debt for his painstaking photomicrographs, and for the excellent collection of clinical photographs accredited to Fordyce and MacKee. His contributions to the modern therapy of syphilis and his investigations of neurosyphilis need not be described here.

FOX-FORDYCE DISEASE: *Chronic itchy papular disease of the axilla, pubes, etc.*

George Henry Fox was born near Saratoga, N. Y., on Oct. 8, 1846. He is one of the earliest specialists in dermatology in America. He is one of the charter members of the American Dermatological Association,

and was its president from 1892 to 1893. He has held many honors; he was professor of dermatology at Columbia University for twenty-six years. He has done much for the specialty, and has added a distinguished member to its ranks in his son, Howard Fox. The disease which bears the names of the collaborators, Fox and Fordyce, was first described in the *Journal of Cutaneous Diseases* (**20:** 1, 1902).

Crocker considered the disease as a porokeratosis of the axilla, but modern ideas include it in the group of the so-called "neurodermites."

G. H. Fox is an ardent photographer. He published a number of photographic atlases illustrating smallpox, diseases of the skin and syphilis. A mood in which he is most lovable has found expression in: "Dermatologic Etymology" (*Arch. Dermat. & Syph.* **3:** 404 [April] 1921).

Fig. 14.—W. Tilbury Fox (after Collection College of Physicians).

IMPETIGO OF TILBURY FOX: *Streptococcic impetigo; impetigo contagiosa.*

William Tilbury Fox was born in Broughton, England, in 1836. He was the son of Dr. L. O. Fox. Tilbury Fox was the Gold Medal Student at University College, London, 1853-1858. He was house surgeon at Lying-In Hospital, Lampeth. A little later (1864), he practiced dermatology with his brother, Thomas Fox. He made a trip to Egypt and India. He studied parastic fungi attacking the skin and hair. He investigated tropical skin diseases. He has been accredited with the first descriptions of porrigo, 1864 (the present impetigo); of dyshidrosis (*Brit. M. J.* **2:** 365, 1873; *Am. J. Dermat. & Syph.* **4:** 1, 1873), of hydroa (*Arch. Dermat.* **6:** 16, 1880) and of dermatitis herpetiformis (Duhring's Disease) (*Arch. Dermat.* **6:** 16, 1880 [a posthumous paper edited by Colcott Fox]). Tilbury and Colcott Fox described the first case of lymphangioma (*London Path. Soc. Trans.* **30:** 470, 1879). Tilbury Fox described the xanthelasmoid type of urticaria pigmentosa.

He made great advances in impetigo. He proved that impetigo could be experimentally inoculated, and the name of impetigo contagiosa was attracted to the condition. Fox's paper appeared in the *British Medical Journal* (**1**: 78, 467, 495, 553, and 607, 1864) also in the *Journal of Cutaneous Medicine* (**3**: 231, 1860). Fox's book on skin diseases was published in London in 1873; an atlas in 1877 and "Classification of Skin Diseases" in 1864. Fox also revised "A Manual of Clinical Medicine and Physical Diagnosis," 1876.

Tilbury Fox died on June 7, 1879.

GERHARDT'S DISEASE: *Erythromelalgia.*

Carl Adolf Christian Jacob Gerhardt was born at Speier, Germany, May 5, 1833. He studied medicine at Würzberg. He was the author

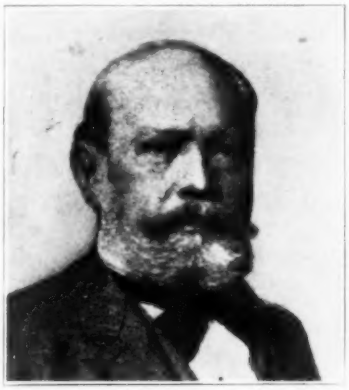

Fig. 15.—Carl Adolf Gerhardt (after Pagel).

of numerous medical articles and books on diseases of children and medical subjects. His paper on the disease to which his name has been linked was published in the *Berliner klinische Wochenschrift* (**29**: 1125, 1892). Gerhardt wrote essays on atelectasis, thrombosis of the cerebral vessels and congenital heart disease. He was professor of theory and practice at Jena, Würzberg and Berlin.

Gerhardt died in 1902.

GIBERT'S DISEASE: *Pityriasis rosea.*

Camille Melchoir Gibert was born in Paris in 1797. He studied at the St. Louis Hospital, and left about 1834. He was an energetic representative of Willan's system in France. He was the author of "Manuel des maladies speciales de la peau," 1834; and "Manuel des maladies veneriennes," 1836. A description of the disease which bears

his name may be found by his pen in "Traite pratique des maladies de la peau," second edition, 1860, page 402. The last treatise has been translated into Italian and English. Gibert recognized the importance of parasitic diseases among school children (*Cong. inter. de hyg.* **2:** 444, 1883).

Gibert published a classification of skin diseases (*Rev. méd. franç. et etrang.* **2:** 481, 1845.

Gibert died in 1866.

GILCHRIST'S DISEASE: *Blastomycosis.*

Thomas Casper Gilchrist was born in England, June 15, 1862. He came to America in 1890. He is a member of the American Dermatological Association, and was its president from 1908 to 1909. He is professor of dermatology at Johns Hopkins University. The disease which bears his name was studied and reported as a "Case of Blastomycetic Dermatitis in Man" (*Johns Hopkins Hosp. Rep.* **1:** 269, 1896, seven plates; ibid. **15:** 56, 1904; *Brit. M. J.* **2:** 1321, 1902). The name of *Oidium gilchristi* has been given to one form of the parasite. Gilchrist has made a study of the acne bacillus (*Johns Hopkins Hosp. Rep.* **9:** 420, 1905), the contents of the bullae of pemphigus (*Trans. Am. Dermat. Assn.*, 1899, p. 96), mast cells, (*Johns Hopkins Hosp. Bull.* **7:** 140, 1896) and the streptococci in the vesicles of impetigo, etc. (*Trans. Am. Dermat. Assn.*, 1900, p. 87). Gilchrist reported an excess of indican in patients with urticaria (*Am. Dermat. Assn.*, 1899). He did some work on urticaria factitia (*J. Cutan. Dis.* **23:** 122, 1908). He reported an unusual type of case of pityriasis rubra followed by peripheral gangrene of the right hand and left foot (*Brit. M. J.*, Oct. 6, 1906). In 1920, Gilchrist published a later edition of his "Outline of Common Skin Diseases Including Eruptive Fevers."

GIOVANNI'S DISEASE: *Rare nodular disease of the hair.*

Sebastiano Giovanni was an Italian who studied skin sections of alopecia areata and reported the results (*Ann. de dermat. et de syph.* **2:** 921, 1891). He contributed to the histology of keratosis pilaris (*La Sperimentale*, **34:** 661, 1895; abstr., *Brit. J. Dermat.* **8:** 151, 1896).

GOLDSCHEIDER'S DISEASE: *Epidermolysis bullosa.*

John Karl August Eugene Alfred Goldscheider was born in 1858. He wrote a paper on "Hereditare Neigung zur Blassenbilding" (*Monatsh. f. prakt. Dermat.* **1:** 163, 1882). Tilbury Fox is accredited with describing two cases of this disease in 1879. A summary of the condition by Wallace Beatty appeared in the *British Journal of Dermatology* (**9:** 301, 1879).

Goldscheider contributed a number of studies on the nerves and sensibilities of the skin, including a book on "Diagnostik der Nervenkrankheiten" (Berlin, 1893); and "Das Schmerzproblem" (Berlin, 1920).

GREENHOW'S DISEASE: *Vagabond's disease; pediculosis corporis.*

Edward Headlam Greenhow was born in England on Dec. 10, 1814. His father and grandfather were physicians. He studied at Edinburgh, Montpelior, and Guy's Hospital, London. He made numerous reports on his multiplex activities in public health and medicine, as that on diphtheria, bronchitis and Addison's disease. He published his cases of the disease to which his name has often been applied as, "Vagabond's Disease Simulating Morbus Addisonii (*London Clin. Soc. Trans.* **9:** 44, 1876). This disease constituted the pityriasis nigra of Willan.

Greenhow died on Nov. 22, 1888.

GRINDON'S DISEASE: *Peculiar affection of the hair follicle; ecbolic folliculitis.*

Joseph Grindon was born on Aug. 20, 1858. He is a prominent dermatologist and professor of dermatology and syphilology in St. Louis. The disease which he described and to which his name is attached was described in the *Journal of Cutaneous Diseases* (**15:** 256, 1897). Grindon reported the cutaneous phenomenon of typhoid fever in 1893. He made an admirable study of recurrent zoster (*J. Cutan. Dis.* **13:** 191 and 252, 1895). Grindon delivered a series of three lectures on medical history from Hippocrates to Harvey in 1907. He published the "Manual of Diseases of the Skin," 1902; and "Cutaneous Therapeutics," 1907 (with Hardaway).

GRUBY'S DISEASE: *Tinea tonsurans.*

David Gruby was born in Hungary in 1810. He studied in Vienna and specialized in anatomy. Restriction against Jews as to operating turned Gruby to microscopy. He went to Paris to work about 1839. His work was interesting and thorough, but he received little recognition during his life time. Only recently has the same type of work been reviewed by Sabouraud. Gruby made many of his contributions as, "Memoire sur une vegetation qui constitue le vrai teigne," in the *Competes rendus hebdomadaires des séances de l'Académie des sciences*, Paris (**13:** 72, 1841; **15:** 12, 1842; **17:** 302, 1843). He published his observations on tinea favosa (alopecia) in *Müller's Archiv.* (1842, p. 22). He described a contagious tinea sycosis or mentagra (porrigo decalvans or phyto-alopecia) and a second form of fungus in tinea tonsurans. Other papers on favus were published (*Compt. rend. Acad. de sc.* **13:** 309, 1841; **18:** 583, 1844). Although Schoenlein first demonstrated

the fungus which Remak named after him, he did not recognize its etiologic significance, which was first demonstrated by Gruby in 1841.

Gruby died in 1898. He had wanted to be alone, and his body was found after the door of his room was broken into several days after he had died.

GULL'S DISEASE: *Myxedema.*

Sir William Whithey Gull was born in England on Dec. 31, 1816. He was at Guy's Hospital, London, and he was professor of physiology. He was preeminent as a clinical physician, and held the post of physician to Queen Victoria. The article on the disease ascribed to him appeared in the *Transactions of the London Clinical Society* (**7:** 180, 1874). Gull also published a paper on "The Various Dermatological Classifications of Authors, with Some New Hints on Skin Diseases" (*Assn. M. J.*

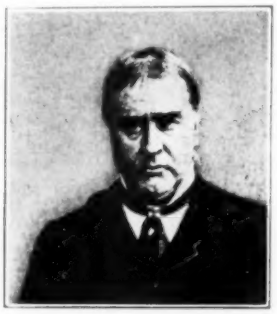

Fig. 16.—William Gull (after Garrison).

4: 453, 1856). A collection of his published writings edited by T. D. Acland appeared in the "New Sydenham Society Volume" for 1894, about four years after Gull died.

HALLOPEAU'S DISEASE: *Pyodermite vegetans; dermatitis vegetans; pustular dermatitis.*

Francois Henry Hallopeau was born on Jan. 17, 1842. He was a student of Vulpian and Janoud until 1871. He studied diffuse sclerosis and the action of mercury. The disease which bears his name was described by him before the International Congress of Dermatology held at Paris in 1889 (*Compte rendu*, reported also in *Ann. de dermat. et syph.* **60:** 696, 1898; *Arch. f. Dermat. u. Syph.* **43:** 289, 1898; **45:** 323, 1898). Hallopeau described lichen planus sclerosus (1889). He also described acrodermatitis continue (acrodermatitis perstans) (*Rev. gén. de chir. et de therap.* **12:** 97, 1898; and page 838 of Hallopeau and Leredde). Hallopeau, who was a corresponding member of the American Dermatological Association, died recently.

HANSEN'S (DISEASE): *Bacillus of leprosy.*

Gerhard Armauer Hansen was born in Norway, on July 29, 1841. He early made his mark in microscopic anatomy. He studied leprosy, especially as to its pathology, causation and manifestation in the eye (1873). His early training was under Daniellsen and Boeck, authorities on leprosy. Under Hansen's direction, a system of isolation of lepers was established in Norway, with the result that the number of cases was reduced from 2,833 to 445, and the new cases each year from 242 to nineteen. In June, 1902, Hansen estimated the number of lepers in the whole of Norway as 400. By establishing the causal relation of the bacteria of leprosy, Hansen revolutionized the conception of the disease.

Fig. 17.—Francois Henry Hallopeau (after Collection of Academy of Medicine, New York).

His papers on leprosy extended over a number of years. The following are given as epoch-making: "Zur pathology der Lepra" (*Arch. f. Dermat.*, 1871, p. 194), "Leprabacillen" (*Virchow's Arch. f. path. Anat.* **88**, 1879; **79:** 32, 1880).

Hansen was an honorary member of the American Dermatological Association and president of the International Leprosy Congress in 1910. He died suddenly, on Feb. 11, 1912.

HEBRA'S DISEASE: *Erythema multiforme.*

Ferdinand von Hebra was born in Brünn, Austria, on Sept. 7, 1816. He was a proficient scholar, and Skoda (1805-1881) gave him charge of the skin clinic. Insignificant when he first began, the skin depart-

ment under Hebra assumed world fame by reason of the clinical study of diseases of the skin, as fostered by Hebra. He has been variously called the "remarkable man of dermatology," the "reformer of dermatology," the "founder of the histologic school of dermatology," the "master of skin therapy," and the man "who rationalized dermatology." In his day, Hebra was the greatest medical man in Vienna, and attracted many adherents to his school from all over the world. Hebra himself traveled in France and England in 1872. He died in 1880.

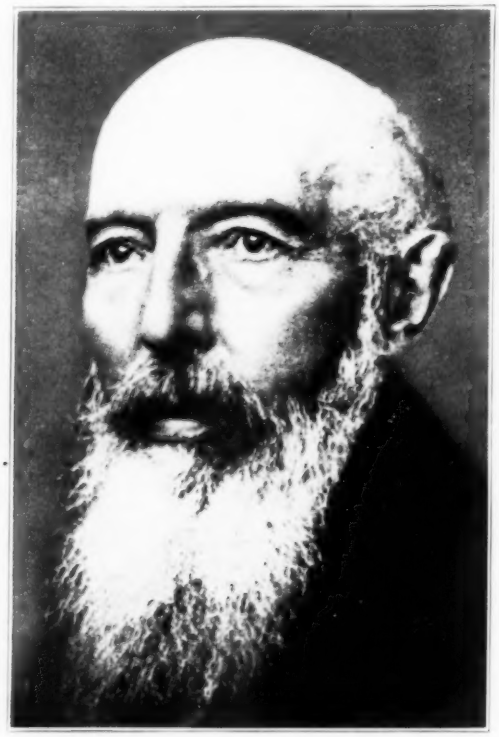

Fig. 18.—Gerhard Armauer Hansen (after Galerie hervorrangender Aerzte).

Hebra had the gift of observation, and many descriptions of disease were original with him. He distinguished the syndrome of erythema multiforme from the heterogeneous group of the erythemas (*Arch. f. Dermat.* **1**: 249, 1869). He studied eczema marginatum (*Handb. d. spec. Path. u. Therap.* [Virchow] **3**: 31 and 361, 1860), after Baerensprung, however. Hebra was the first to describe impetigo herpetiformis (*Wiener med. Wchnschr.*, 1872, No. 48, p. 1192-1201). A translation appeared in the *American Journal of Syphilis and Dermatology* (**4**: 156, 1873; *Lancet*, March 23, 1872). A full account of this

disease was given by Kaposi in 1887 (*Viertelj. f. Dermat. u. Syph.* and *Arch. f. Dermat.*, 1887, p. 273). Hebra also described a morbid type of pruriginous disease known as Hebra's prurigo, or prurigo ferox. He also described lichen rubra, also known as pityriasis rubra, or Hebra's pityriasis. The first clearly described case was that of an Englishman, Claudius Tarral, communicated to his former teacher, Rayer, from St. Bartholomew's Hospital in 1828 (*Hautkrankheiten* **1:** 298, 1874). Another disease to which Hebra's name has been linked is lupus disseminatus. Rhinoscleroma was first described by Hebra (*Wien. med. Wchnschr.*, 1872). Acne cachecticorum follicularis, or acneform tuberculid, or lichen scrofulosorum, has been named Hebra's disease. Texts

Fig. 19.—Ferdinand von Hebra (after Garrison).

accredited to Hebra include "Handbuch für Dermatologie," Hebra-Kaposi, 1876, a translation of which appeared as "Diseases of the Skin" (*New Sydenham Society Trans.*); Atlas der Hautkrankheiten, 1856-1876. Hebra, under the influence of Rokitansky (1804-1878), founder of pathologic anatomy, applied the general principles of pathology to skin diseases, and proposed a pathologic-anatomic system embracing twelve classes. Certain inconsistencies have evolved, which have become more striking with time albeit not noticeable at the time proposed.

HENOCH'S PURPURA: *Purpura fulminans.*

Eduard Heinrich Henoch was born in Berlin, Germany, on June 16, 1820. He completed his medical studies in 1843. He was a student of Rhomberg and Schoenlein. Henoch was especially interested in

pediatrics, and published "Beitrage zur Kinderheilkunde" in 1861, which was translated into English (several editions) and Polish. His original contribution to the disease which bears his name is given as, "Ueber eine eigentümliche Form von Purpura" (*Berl. klin. Wchnschr.* **11**: 641, 1874). According to Osler, Robert Willan (1757-1812) first described Henoch's purpura with visceral symptoms.

Henoch died in 1900.

HIPPOCRATIC MORBUS NIGER: *Icterus gravis.*

Hippocrates was born on the island of Cos about 460 B. C. After the death of his father, Hippocrates went to Athens for the study of surgery. The profession of medicine owes to him the art of clinical

Fig. 20.—Eduard Heinrich Henoch (after Garrison).

inspection and observation. He has been named "The Father of Medicine," and the physician's oath has been named the Hippocratic oath, although it is far fetched to consider him its author. Hippocrates was the founder of Grecian dermatology. His was the period of symptomatic designation of diseases of the skin, and some of the names persist, such as alopecia, hydroa, psora (itching disease) lepra (scaly disease), etc.

Hippocrates differentiated falling of the hair due to age as "madisis," and that due to disease as "alopecia." We still use this term. Hippocrates knew of congenital alopecia. Calvities Hippocratica is the designation for a type of total baldness. Hippocratic nails are those resulting from chronic pulmonary and cardiac disease.

The Sydenham Society published "The Genuine Works of Hippocrates" in 1849. Numerous other translations, commentaries, etc., are extant.

Hippocrates died in 377 B. C.

HODARA'S DISEASE: *Trichorrhexis nodosa (?) of women of Constantinople.*

Menahem Hodara was a Turk. He described a peculiar bacillus, *Bacillus multiformis* of trichorrhexis (*Monatschr. f. prakt. Dermat.* **19:** 173, 1894; *Arch. f. Dermat.* **41:** 1, 1894; *Mal cutan.* **6:** 641, 1894). Hodara wrote a paper on the histology of erythema of infants' buttocks

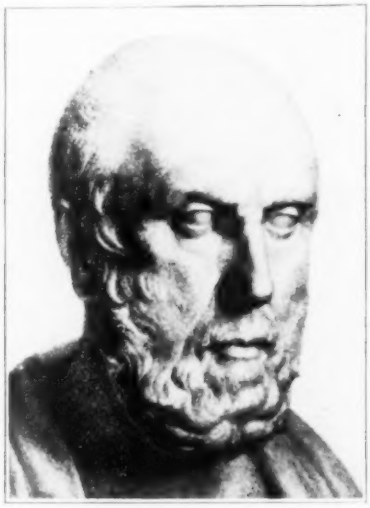

Fig. 21.—Hippocrates (after Collection of Academy of Medicine, New York).

(*Monatschr. f. prakt. Dermat.* **26:** 325, 1898). He also presented a review with bibliography, histology, etc., of parakeratosis variegata (Unna) (*Dermat. Wchnschr.* **55:** 848, 1912).

HODGKIN'S DISEASE: *Granuloma leukemia.*

Thomas Hodgkin was born in Tottingham, England, on Jan. 16, 1798. He was a member of the Society of Friends. He studied at Edinburgh and received his degree of doctor of medicine in 1823. He became a member of the Royal College of Physicians, London. Hodgkin was the friend and medical adviser of Sir Moses Montifiore, with whom he traveled extensively (*Ann. Med. Hist.* **3:** 381, 1921).

Hodgkin recorded that the disease which now bears his name had been vaguely outlined by Malpighian in 1665. Wilkes independently discovered the disease, but with a generous desire to perpetuate the name of his teacher, he gave the morbid state the name of Hodgkin's

disease (Samuel Wilkes: "An Account of Some Unpublished Papers of the Late Dr. Hodgkin," *Guy's Hosp. Rept.* **23:** 53, 1878).

Hodgkin wrote an account of insufficiency of aortic valves (*Lond. Med. Gaz.* **3:** 433, 1828-1829). This paper antedated that of Corrigan by three years.

Hodgkin died on April 5, 1866, in Jaffa on his way to the Holy Land.

"The Life and Letters of Thomas Hodgkin" by Louise Creighton was published in 1917.

HUNTERIAN CHANCRE: *A type of primary lesion of syphilis.*

John Hunter was born at Long Calderwood, Scotland, on Feb. 13, 1728. He became a pupil and later assistant of his brother, William

Fig. 22.—Thomas Hodgkin (after Garrison).

Hunter. At the age of 20, John Hunter became an assistant in anatomy, and soon not only became as famous as his brother as a surgeon, but surpassed him ("Lectures on Principles of Surgery"). Hunter personally prepared over 10,000 museum specimens (at a cost of 70,000 pounds), which is part of the collection of the Royal College of Surgeons. He made numerous studies, including one on the teeth, 1771. Hunter's name comes to us as having been that of the man who clearly differentiated the hard (hunterian) chancre and the soft chancre (chancroid), but he confounded gonorrhea with syphilis. At the age of 40, Hunter unfortunately inoculated himself in the famous experiment of using supposedly gonorrheal pus on a nonmucous surface, and acquired syphilis. He developed angina pectoris, often foretold that his end

would be decided at the will of any churlish lad, and indeed he died in an attack brought on by anger on Oct. 16, 1793.

The description of the induration of the initial lesion of syphilis which has received the appelation of hunterian chancre has been accredited to John Andree (*Proksch. Geschichte der venerischen Krankheiten* **2:** 525).

Hunter's complete works have been translated into French, and some contributions into German. It is said that twenty or thirty large folio volumes of unpublished observations on comparative anatomy and physiology were stolen and burned by a nephew, who later published the material as his own.

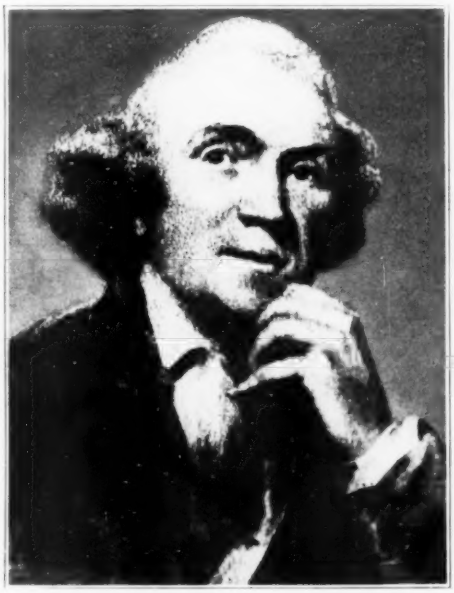

Fig. 23.—John Hunter (after Collection of Academy of Medicine, New York).

A number of memoirs of this brilliant man, his life and work have been published, as well as a book, "John Hunter, Man of Science and Surgeon," 1898.

HUTCHINSON'S DISEASE: *Infective angioma or nevus lupus.*

Jonathan Hutchinson was born in Selby, England, on July 23, 1828. He studied at York and London. He was a Fellow of the Royal College of Surgeons, and a professor of surgery (Clinical Surgery, 1878). He was surgeon to an ophthalmic hospital (Diseases of the Eye, 1863). He became interested in the diseases of the skin and syphilis. He wrote a

clinical memoir on certain diseases of the eye and ear consequent on inherited syphilis (*Arch. Surg.* **1:** 289, 1889-1890; **2:** 71 and 111, 1890-1891; **3:** 116, 1891-1892). Here was described the Hutchinson triad.

Hutchinson described the first four cases of infective angioma (*Arch. Surg.* **3:** 166, 1891-1892). He proposed the hypothesis of fish eating as the cause of leprosy ("Leprosy and Fish Eating," London, 1906). He was the first to describe varicella gangrenosa (*Med. Clin. Trans.* **54:** 1, 1882). He independently described dyshidrosis, later ascribed to Tilbury Fox (*Lancet,* 1876, p. 630; *Ill. Clin. Surg.* **1:** 49, 1876; *London. Med. Chir. Trans.,* 1882, p. 1). Hutchinson described lupus marginatus (Hillard's lupus) (*Polyclinic J.* **2:** 104, 1900), also Mortimer's malady (*Arch. Surg.* **9:** 307, 1898, Plate clii).

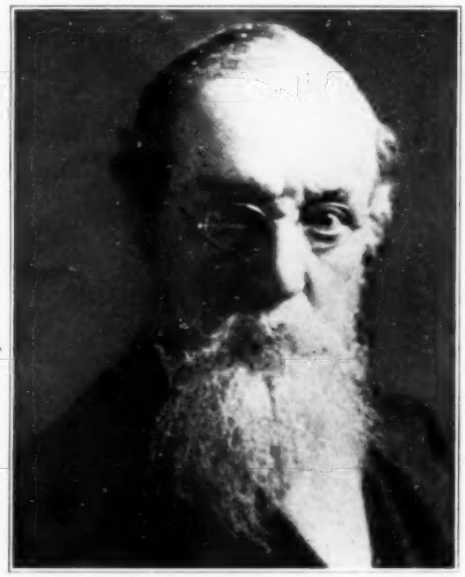

Fig. 24.—Jonathan Hutchinson (after Galerie hervorrangender Aerzte).

HUTCHINSON'S TEETH: *Notched spade upper incisors.*

These teeth have been widely recognized, and were first described by Hutchinson ("Natural History of Teeth," Part 1, 1776, and Part 2, 1778). He published a paper on "Heredosyphilitic Struma and on Teeth as a Means of Diagnosis" (*Brit. M. J.* **1:** 515, 1861).

HUTCHINSON'S DISEASE: *Recurrent summer eruption.*

This disease was first described by Bazin as hydroa vacciniforme. Hutchinson's paper was called, "A Case of Summer Eruption" (*Clin. Soc. Trans.* **22,** 1888).

Hutchinson also described a type of erythema induratum, known as Hutchinson's type, in which the erythema induration not infrequently gives rise to sluggish and obstinate ulcers.

Hutchison was recognized as an authority both in his own country (he was knighted) and in foreign countries. He was an honorary member of the American Dermatological Association. He was the author of numerous monographs and texts, and was the sole contributor to the *Archives of Surgery*, which he published.

Hutchinson died in 1913.

Fig. 25.—James Nevins Hyde (after American Dermatological Association portraits).

HUTINEL'S DISEASE: *Infectious erythema of typhoid, etc.*

Victor Hutinel was born in France, on April 15, 1849. He was a brilliant medical student; he received a gold medal on work in Parrot's pediatric clinic. He wrote several treatises on circulatory conditions; one on convalescence after typhoid fever; and numerous articles on syphilis, especially in young people.

HYDE'S DISEASE: *Prurigo nodularis.*

James Nevins Hyde was born in Norwich, Conn., on June 21, 1840. He studied medicine at the College of Physicians and Surgeons, New York, and saw service during the Civil War, and later. He was the pioneer dermatologist of Chicago, having begun the practice of the specialty there in 1873. He was a member of many dermatologic societies and one of the founders of the American Dermatological Association, and its third president, as well as president in 1896. He was a teacher of ability. He was the author of more than 100 special articles. His treatise on "Diseases of the Skin," 1883, has gone through eight editions.

The condition to which Hyde's name has become attached was first described by Hardaway (*Arch. Dermat.* **6:** 161, 1880). Hyde gave the disease its name. This disease is reviewed in an article by Zeisler (*J. Cutan. Dis.*, Nov., 1912).

Hyde died on Sept. 6, 1910.

JACOB'S ULCER: *Rodent ulcer of the face.*

Arthur Jacob was born in Dublin, Ireland, on June 13, 1790. He was a student of Abraham Colles. He was especially proficient in his anatomic studies, especially the eye.

Jacob died in 1874.

JACQUET'S DISEASE: *Reflex alopecia as connected with anomalies of teeth.*

JACQUET'S DISEASE: *Dermatitis simplex infantiles.*

Lucien Jacquet was born in Sauviat in 1860. In 1896, he became physician to the Hopitaux St. Antoine, where he initiated the dermatologic service. This clinic, under his direction, became second only to that at St. Louis, Paris.

The second disease mentioned above as linked with Jacquet's name was first described by Parrot in 1877. Jacquet's description, "Des erythemas papuleux fessiers post erosifs" appeared in 1889 (*Rev. d. mal. de l'enf.*, **4:** 208, 1889; *La Pratique Dermat.* **1:** 873, 1900; *Traite des mal. de l'enfance* **4:** 714, 1905).

Jacquet made many studies of eczema and urticaria. He began the anti-alcohol campaign in France. He was joint editor of *Precis elementaire de dermatologie* with Brocq; also of *Annales de dermatologie et de syphilis.*

Jacquet died in 1915.

JADASSOHN'S DISEASE: *Anetoderma erythematosum; macular atrophy.*

Josef Jadassohn was born at Nerm, on Sept. 10, 1863. He was a pupil of Neisser. He has earned a high reputation as a teacher of dermatology. He has made a number of original investigations, including studies on nevi, tuberculosis of the skin (Mracek's "Handbuch") pityriasis rubra (1882), verruca, favus, tumors and drug eruptions, as well as describing for the first time the disease named after him; also cutis verticis gyrata (*Verhandl. d. deutsch. dermat. Ges* **9:** 451, 1907); granuloma rubra nasi ("Ueber eine eigenartige Erkrankung der Nasenhaut bei Kindern," *Arch. f. Dermat.* **58:** 145, 1901).

Jadassohn proposed a classification of skin diseases which was chiefly etiologic or physicopathologic (*Ergebn. d. spez. path. Morph. u. Physiol. d. Sinnesorg*, 1896, p. 271). He edited the German edition of Darier's textbook, and is a corresponding member of the American Dermatological Association.

KAPOSI'S DISEASE: *Xeroderma pigmentosum.*

Moritz Kaposi (Moritz Kohn) was a Hungarian, born in Kaposvar, on Oct. 23, 1837. He studied in Vienna from 1856 to 1861. He was taken up by Hebra, and became his successor. His first large work was on the syphilitic lesions of the mucous membranes. The first mention of xeroderma pigmentosum was made in Hebra's textbook on Skin Diseases (**3:** 282), and later there appeared memoires ("Xeroderma pigmentosum," *Wien. med. Jahrb.* 1882, p. 616, 5 plates; *Wien. med. Wchnschr.*, 1885, p. 1335; *Twentieth Century Practice* **5**). According to Corlett, Wilson referred to this disease.

KAPOSI'S DISEASE: *Lichen ruber acuminatus or moniliformis.*

This disease, admitted to be identical with Devergie's pityriasis rubra pilaris, was described by Kaposi (*Vrtlschr. f. Dermat.* **13:** 572, 1886).

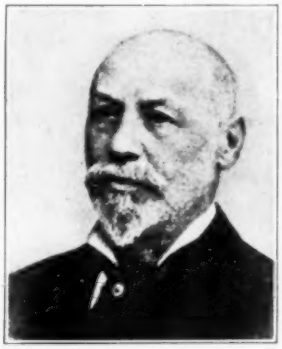

Fig. 26.—Moritz Kaposi (after Pagel).

KAPOSI'S SARCOMA: *Multiple idiopathic pigmented sarcoma.*

The description of this disease is admittedly Kaposi's best work (*Path. u. Therap. der Hautkrankh.* Ed. 5, p. 922; *Arch. f. Dermat.* **4:** 265, 1872).

Kaposi is accredited with the original descriptions of other diseases, such as impetigo herpetiformis (*Vrtljahrschr. f. Dermat.* **14:** 273, 1887); pemphigus vegetans, which he had named syphilis vegetans; lupus erythematosus disseminatus (*Arch. f. Dermat.* **4:** 36, 1872), and dermatitis papillaris capillitii ("Hautkrankheiten," 1880). The last is said to have been described earlier by Bazin, and considered as sycosis frambesiformis by Hebra.

Kaposi described a bulloserpiginous form of gangrene apt to occur in advanced cases of diabetes mellitus (*Wien. med. Wchnschr.* Nos. 1,

2, 3 and 4, 1884). He was the first to describe a case of lymphangioma tuberosum multiplex from Hebra's atlas, Plate 6 (also Hebra **3:** 387).

Kaposi's text for physicians was translated into French by Bessnier and Doyen, and there has also been an English edition. He published more than 150 articles.

Kaposi died on March 6, 1902.

KÖBNER'S DISEASE: *Epidermolysis bullosa hereditaria.*

Heinrich Köbner was born in 1838. The disease which he reported as "Hereditare Anlage zur Blasenbildung" (*Deutch. med. Wchnschr.* **12:** 21, 1886) has been accredited to him. He reported the literature (*Arch. f. Dermat.* **70:** 125, 1904). Köbner also reported one of the earliest cases of xanthoma (*Viertelj. f. Dermat.* **15:** 393, 1888). He

Fig. 27.—Heinrich Koebner (after Pagel).

also devoted considerable study to parasitic diseases of the skin. He published a volume of clinical and experimental studies in dermatology and syphilis, 1864.

LELOIR'S DISEASE: *Lupus vulgaris erythematoides.*

Henry Camille Leloir was born at Lille, on Nov. 20, 1855. He died on June 18, 1896. He studied at Lille and Paris. He became dermatologist and later professor at Lille. He made many studies and researches, especially in leprosy (Traite pratique et theorique de la Lepre, 1886). He made numerous studies on leukoplakia and tuberculosis. He made especial investigations, as recorded in his text, "Recherches clinique et anatomo-pathologiques sur les affections cutanées d'origine nerveuses" (Paris, 1881). He reported degeneration of the nerve fibers underlying the lesions of pemphigus. His representation of the disease which bears his name was made in the *Journal des maladies cutanées et syphilitiquées* **1:** 65, 177, 178, 241, 263, 304, 475 and 489, 1891). He devoted several papers to lupus vulgaris (*Prog. Med.* **3:** 404, 1892). Leloir had also investigated the anatomy of various

forms of erythema (*Ann. de. dermat. et syph.* **6:** 129, 1885), the formation of pustules and vesicles (*Arch. de physiol.* **7:** 307, 1880) and made a study of skin affections due to trophic nerve disturbances (*Arch. de physiol.* **8:** 391, 1881).

With Vidal, Leloir wrote a descriptive treatise (1889-1891), which ran a Russian and a German edition.

MAJOCCHI'S DISEASE: *Purpura telangiectoides annularis (1895).*

(Domenico) Majocchi is an Italian dermatologist. The disease to which his name has been linked was first described by him in *Giornale italiano delle malattie venere e delle malattie della pelle* **31:** 263, 1896; **33:** 638, 1898. Majocchi was the first to describe actinomycosis occurring in the skin.

Fig. 28.—Jean Nicoles Marjolin (after Collection of Academy of Medicine, New York).

MARJOLIN'S ULCER: *Cancerous ulcer of the leg.*

Jean Nocoles Marjolin was born in Scey sur Saone on Dec. 6, 1780. He studied at Commercy and later at Paris. He became assistant in anatomy and later surgeon at the L'hotel Dieu de Paris, where he was later still named professor in pathology. He was an able practitioner. He wrote numerous papers and texts: "Propositions de Chirurgie et de Medicine," 1808; "Manuel d'Anatomy," 1810; "Del l'operation de la hernia inguinale estranglee," 1812, etc.

He died in Paris on March 4, 1850.

MAURIAC'S DISEASE: *Erythema nodosum syphilitica.*

Charles Mauriac was born at Saint Aquelin, on Nov. 13, 1832. He was noted as a syphilologist and genito-urinary specialist. He published

numerous medical papers and several texts. Among the later may be mentioned, "Titres et travaux scientifiques du Docteur Charles Mauriac" (Paris, 1881); "Pathologie generale de la syphilis tertiare" (Paris, 1886), and "Nouvelles lecons sur les maladies venerinnes" (Paris, 1890).

Mauriac died on May 24, 1905.

MEIGE'S DISEASE: *Trophedema; Milroy's disease; congenital edema elephantiasis of the lower limbs.*

Henry Meige was born in France in 1866. He was a student of Charcot. His description of this disease appeared in *Nouvelle iconographie de la Saltpêtrière* (**6:** 433, 1899); *Brit. J. Dermat* (**12:** 372, 1900).

Fig. 29.—Charles Mauriac (after Med. Mod.).

MIBELLI'S DISEASE: *Angiokeratoma.*

Vittorio Mibelli was an Italian dermatologist. The disease which Mibelli reported before the International Congress of 1889 (*Trans.*, p. 899) and of which he gave a classical description (*Gior. ital. Dermat.* **24:** 285, 1899) had been previously noted. The first description was given by W. Cottle (*St. George Hosp. Rept.* **9:** 758, 1877-1878). Other cases had been described by Zeisler, Crocker, and others. Mibelli also reported a case (*Inter. Atlas* **2:** 1889; *Monatschr.* **24:** 428, 1897).

MIBELLI'S DISEASE: *Porokeratosis.*

This disease was also described by Mibelli in the "International Atlas" (**9:** 1893; Plate xxvii). He contributed, "Beitrage zum Studium der Hyperkeratoses der Knaweldrusen, Porokeratosis"

(*Monatschr.* **20:** 309, 1895; *Ann.* **6:** 503, 1905). He made other contributions (*Gior. ital.* **28:** 356, 313, 1893; *Arch. f. Dermat.* **47:** 1, 231, 1899).

Mibelli published a text, "Malattie della pelle" (Milan, 1901). He explained the cupping of the scutula of favus in *Riforma Medica* (**2:** 37, 1891; **3:** 850, 1891). He discussed the varieties of keratoses (*Monatschr.* **24:** 345, 415, 1897). He proposed a simple method of demonstrating elastic tissue (*Monitore zool. ital.* **1:** 17, 1890).

Mibelli was a corresponding member of the American Dermatological Association before he died.

MILROY'S DISEASE: *Congenital edema of the legs.*

William Forsyth Milroy was born on Dec. 28, 1855. He is a professor of medicine at Omaha. The disease which bears his name was

Fig. 30.—Silas Weir-Mitchell (after Garrison).

reported as, "An Undescribed Variety of Hereditary Edema" (*New York M. J.* **106:** 505, 1892). Other medical publications have appeared from time to time.

WEIR-MITCHELL'S DISEASE: *Erythromelalgia.*

Silas Weir-Mitchell was born in Philadelphia, on Feb. 15, 1829. He was the son of a prominent physician and professor of medicine at Jefferson Medical College. Mitchell graduated in medicine in 1850. His life has been an inspiration to many physicians, and in addition to high attainments in the art of medicine, Mitchell was well known for his skill as a novelist, biographer and poet. The disease which bears his name was described in the *Philadelphia Medical Times* (**3:** 81, 113, 1872; *Am. J. Med. Sc.* **76:** 17, 1878; *Med. News Phila.* **45:** 717, 1884). It is said that Paget made an early note on this disease and that Graves gave an independent description (*Clin. Sect.*, Dublin, 1864, p. 826). Weir-Mitchell also described glossy skin or atrophoderma neuritica (Injuries of Nerves and their Consequences, Phila., 1872).

A brief sketch of the life of Mitchell was published in Boston in 1914.

MOELLER'S GLOSSITIS: *Chronic superficial excoriation of the tongue.*

Moeller was born in Germany in 1829. He died in 1862. The disease which bears his name was reported in *Deutsche Klinik* (**3:** 273, 1851). The disease was redescribed by Michelson in 1890.

MORTIMER'S MALADY: *Obscure disease included in sarcoma cutis.*

This was described by Hutchinson (*Arch. Surg.* **9:** 307, 1898, the patient's name for the type case was Mortimer).

Fig. 31.—Isidore Neumann (after Pagel).

MORVAN'S DISEASE: *Syringomyelia.*

Augustin Marie Morvan was born in Lanniles, France, in 1819. He died in 1897. There is an extended memoire on the disease which bears his name, "De la paresis analagesique a panaris des extremites superieures ou pareso-analgise des extremites superieures," *Gaz. hebdom.* **20:** 580, 590, 624 and 721, 1883). There is a lecture by Charcot in transalation (*Phila. Med. Bull.*, 1890, Nos. 10 and 11).

NETTLESHIP'S DISEASE: *Urticaria pigmentosa.*

This disease was described as "chronic urticaria leaving brown stains" (*Brit. M. J.*, Sept. 18, 1869). The name was given by Sangster in 1878. Paul Raymond in "L'Urticaire pigmentair" (Thesis de Paris, 1888), gave a summary of a number of cases (twenty-nine) to that date.

NEUMANN'S DISEASE: *Pemphigus vegetans.*

Isidore Neumann was born at Nesslitz, Moravia, on March 2, 1832. His full name was Isidore Neumann von Heilwart. He studied at Vienna with Hebra, and has been known for his masterly clinical and

histologic presentations. His textbook ran through many editions and was one of the earliest German dermatologies translated into English. Neumann made special studies of the lymph vessels of the skin (*Phila. Med. Times* **3:** 679, 1872) and of agyria. He published a contribution on pemphigus vegetans (*Viertelj. f. Dermat.* **13:** 157, 1886, 4 plates); also "Die Syphilis der Haut" (1873, Plates 63 and 64). This disease had been studied in turn by Alibert, 1833; Kaposi, 1869; and Neumann, 1886. Unna regarded the disease as vegetating erythema bullosum.

Neumann was the first to describe alopecia cicatrisata, although imperfectly. He made a classification of skin diseases, fully aware that no system could be entirely satisfactory. In the main, Neumann's system was a modification of that of Hebra. Neumann was the author of numerous books on dermatology and of pathology of the skin. He also wrote on venereal diseases, including syphilis, and made a special study of the histopathology of cutaneous and general syphilis.

Neumann was an honorary member of the American Dermatological Association. He died on Aug. 31, 1906.

NOCARDIOSIS: *Parasitic affection somewhat like actinomycosis.*

Edmond Isidore Etienne Nocard was born in Provins, on Jan. 29, 1850. He studied at the school of Alfort, and was one of the collaborators of the distinguished Pasteur. He was made chief of the veterinary department at Alfort and later professor of contagious diseases among animals. He was a member of the Academy of Medicine, and was decorated for the Legion of Honor, of which he was made an officer in 1892. Nocard wrote many articles which have never been collected in one volume. He was one of the co-workers on the "Nouveau Dictionnaire pratique de medicine, de chirurgie et d'hygiene veterinaires." He was the author of "Les tuberculoses animales" and "Les maladies microbiennes des animaux." Nocard maintained the communicability of bovine tuberculosis to man.

He died on Aug. 1, 1903.

PAGET'S DISEASE: *Disease of mammary areola preceding cancer of the mammary gland.*

Sir James Paget was born in Yarmouth, England, on Jan. 11, 1814. He studied at St. Bartholomew's Hospital. Two diseases were named after him; that of the skin as given above was elucidated in *St. Bartholomew's Hospital Reports* (**10:** 83, 1874); also by the New Sydenham Society in 1907. Paget was a surgeon and lecturer in pathology. He was the author of "Surgical Pathology," the first edition of which appeared in 1863 and the third in 1870. A French translation was also published. It is not surprising then that the second disease known as Paget's disease was osteitis deformans (*Med. Clin.* **60:** 37, 1876; **65:** 225,

1881; *New Sydenham Soc.*, 1907). Paget also described an atrophy of the skin in an area of a nerve affected by disease or injury ("Some Forms of Local Paralysis," *Med. Times & Gaz.* **1**: 331, 1864).

Paget delivered the Hunterian Oration on Feb. 13, 1877; the Morton Lecture on Cancer and Cancerous Diseases on Nov. 11, 1887. Several editions of Paget's selected essays and addresses have been published, as well as "Studies of Old Case Books." One of his sons, two years after his father's death, published, "Memoirs and Letters," 1901. This extract from a letter to his wife strikes the eye: "July 17, 1865. My practice is almost gone; and I might shut the shutters without great loss. Unless something new comes in, I may dine to-morrow at half past three; I shall begin to think of taking pupils, or writing a pamphlet—I shall go to the Crystal Palace or Astley's."

Fig. 32.—James Paget (after Garrison).

PAXTON'S DISEASE: *Leptothrix.*

Paxton of Chichester, England, described leptothrix in 1869 as causing a brittle dry condition of the hairs. The disease was named by Erasmus Wilson and later independently described by Pick.

Paxton also described *Streptothrix asteroides* (of Paxton) as found in pus of an abscess of the neck.

PICK'S DISEASE: *Erythromelia.*

Filipp Joseph Pick was born in Prague in 1834. He studied zoology and biology. He was one of the early students of Hebra and one of his assistants. He became one of the leaders of dermatology and was the first full professor of dermatology in Austria (1896). He was an early experimenter, and by inoculation proved the identity of mouse and

human favus (*Arch. f. Dermat.* **23:** 57, 1891) as well as being the first to demonstrate by experimental inoculation the contagious nature of *Molluscum contagiosum*. He compelled the recognition of the tuberculous nature of lupus vulgaris. He independently described leptothrix. Pick published a paper describing the disease associated with his name, "Ueber Erythromelia" (*Arch. f. Dermat.* **31:** 915, 1900). The first observation of this disease was accredited to Buschwald (1883). Pick also made studies on urticaria pigmentosa and acne. He was famous as a therapeutist.

Pick was cofounder with Auspitz of the *Archiv. für Dermatologie und Syphilis,* and later was its editor (1886). He was an honorary

Fig. 33.—Filipp Joseph Pick (after Collection of Academy of Medicine, New York).

member of the American Dermatological Association. He published "Localisations tabellen zur graphischen darstellung des sitzes und der verbreitung von Krankheiten für Kliniken Aertze und Studirende," Prague, 1887.

PINKUS' DISEASE: *Lichen nitidus.*

Felix Pinkus was born on April 4, 1868. The original contribution on the disease, "Ueber eine neue knotchenförmige Hauteruption" appeared in the *Archiv für Dermatologie* (**84:** 11, 1907). Pinkus has written numerous articles on dermatologic subjects, among which may be mentioned: "Der Ausfall des Kopfhaars und seine behandlung" (Samml. Zwangl. abhandl. a. d. g. d. dermatologie **3:** 1914), "Die einwirking von hautkrankheiten auf des kophaars des Menschen" (1917), "Haut u. Geschlechtskrankheiten" (1910) and "Ueber den jetzigen Stand der syphilis Forschung" (*Beihefte zur med. Klin.,* 1907).

POLLITZER'S DISEASE: *Hydradenitis destruens suppurativa; papulonecrotic tuberculid.*

Sigmund Pollitzer was born in 1859. He is an American dermatologist, and one of the first of his countrymen to study seriously under the master, Unna. While abroad, he contributed several studies on physiologic research. He made many histologic investigations, and contributed to the dermatology of the time. The description of parakeratosis variegata is accredited to Unna, Santi and Pollitzer (*Monatschr.* **10:** 404, 1890; abstr. *Brit. J. Dermat.* **2:** 217, 1890). Pollitzer's paper on the disease named at the head of this chapter may be found in the *Journal of Cutaneous Diseases* (**10:** 9, 1892). Pollitzer also described acanthosis nigricans, as did Janowsky (*Intern. Atlas* 1891, plate 10). A discussion of this disease appeared also in *The Journal of the American Medical Association* (**53:** 1369, 1909). Others of Pollitzer's dermatologic studies include: "The Nature of Xanthoma" (*New York M. J.* **2:** 73, 1899; *J. Cutan. Dis.* **28:** 633, 1910), "Recurrent Eczematous Affection of the Hands" (*J. Cutan. Dis.* **30:** 716, 1912), "Seborrhoic Wart" (*Brit. J. Dermat.* **2:** 199, 1890), "Rhinoscleroma cured by X-Ray" (*J. Cutan. Dis.* **28:** 338, 1910, [first case]). Xanthoma has been made the subject of continued study by Pollitzer for many years.

Pollitzer proposed a variation of Scholz's method of intensive introduction of arsphenamin in the therapy of syphilis. He edited the American edition with notes of Darier's Textbook, 1920. He is a member of the American Dermatological Association, and was its president from 1914 to 1915; he is its chairman of committee on statistics (*Arch. Dermat. & Syph.* **7:** 99, 1923).

POTT'S DISEASE: *Chimmney sweep cancer of the scrotum.*

Percival Pott was born in 1714, and died in 1788. He was a surgeon at St. Bartholomews, and he was recognized as a genius. He was a teacher of John Hunter. Pott will be remembered also as the describer of the Pott's fracture. It was while he was in bed, a victim of the fracture he described, that he took time to record some of his experiences, including that with the skin condition with which his name has been associated.

Numerous editions of collections of Pott's works have been published, both in England and in other countries.

QUINCKE'S DISEASE: *Angioneurotic edema.*

Heinrich Ireneus Quincke was born in Germany, 1842. He was the son of a physician. He studied at Heidelberg, Würzburg and Berlin. He made special investigations on blood vessels. He was the first to suggest that there were several varieties of fungi which caused favus.

The disease which bears his name was described as "Ueber akutes umschriebenes Hautedem" (*Monatschr. f. prakt. Dermat.* **1:** 129, 1882). The disease was, however, accurately described and its character recognized previously to Quincke by Bannister.

Quincke was an exceptional student, and his writings covered many fields of medical interest. Among his books may be mentioned, "Balneologische Tafeln," "Krankheiten der Gefässe," "Die Stellung der Medicin zu den anderen Universitätswissenschaften," "Die Techik der Lumbalpunktion" and "Wandlungen der medicin in Wissenschaft und praxis."

QUINCQUAD'S DISEASE: *Acne decalvans.*

Charles Emil Quincquad was born in France, 1841, and died in 1894. The disease was first reported by the man whose name it bears

Fig. 34.—Percival Pott (after Garrison).

(*Bull. Soc. méd. d. hôp.* 1888, p. 385; *Reunions clin. de l'hop. St. Louis* **9:** 17, 1888). Lailler and Robert independently described the same affection under the name of "acne decalvante" (Thesis de Paris, 1889).

RAYER'S DISEASE: *Xanthoma.*

Pierre Francois Olive Rayer was born at Calvados, on March 8, 1793. He studied at Paris. He was an advanced worker in pathology, natural history, therapeutics, epidemiology and diseases of the kidneys, as well as a student of the diseases of the skin. He formulated a new concept of eczema, and was the first to differentiate between acute and chronic eczema. He made various steps in progress over the classification of Willan. Rayer's basis was on the morbid anatomy, and especially in regard to the pathogenic relationships. Rayer had a great influence on Erasmus Wilson. Among Rayer's contributions were: "Atlas" (1826-1827) and "Traite theoretique et pratique des maladies de la peau," 1826. There have been several German and English translations. A study of glanders and farcy appeared (*Mém. Acad. de méd.* **6:** 625, 1837). He fully and accurately described cheilitis exfolia-

tiva as "pityriasis des levres." He reported the first case of adenoma sebaceum (Rayer's Treatise, Ed. 2, Willis trans., p. 996).

Rayer died on Sept. 10, 1867.

RAYNAUD'S DISEASE: *Symmetrical gangrene of extremities.*

A. G. Maurice Raynaud was born in Paris, France, in 1834. He died on June 29, 1881. His thesis describing the affection best known usually as Raynaud's disease was, "Die l'asphyxie locale et la gangrene symetrique des extremites" (*Thesis de Paris*, 1862; *Arch. gen. de méd.* **1:** 189, 1874). A translation appeared in the New Sydenham Society publications in "Monographs of 1888," with valuable notes by Barlow.

Fig. 35.—Pierre Rayer (after Collection of Academy of Medicine, New York).

RECKLINGHAUSEN'S DISEASE: *Multiple neurofibromas and associated skin conditions.*

Frederick Daniel von Recklinghausen was born in Westfallen, Germany, on Dec. 2, 1833. He studied at Borin and Wurzburg. The disease which bears his name was first reported as, "Ueber die multiplen Fibrome der Haut und ihre Bezeihung zu den multiplen Neuromen" (Festschrift, Berlin, 1882). This was an able and important monograph.

Recklinghausen also worked at the Virchow pathological institute. He was the author of "Handbuch der allgemeinen Pathologie" (Stuttgart, 1889); "Die Lymphfasse und ihre Bezeihung zum Bindegewebe" (1862); and "Rachitis und Osteomalacie" (1910).

Another disease which bears Recklinghausen's name is neuroplastic arthritis deformans.

Recklinghausen died in 1910.

RITTER'S DISEASE: *Exfoliative dermatitis.*

Gottfried Ritter von Rittersheim was born in Lemburg, Germany, 1820. He studied at Lemburg and Prague. He was interested in the diseases of children and infants. The disease known as Ritter's disease was claimed by Kaposi to have been previously described by Hervieux, Huetter, Bille and others. Ritter's paper, "Die exfoliative Dermatitis die jungeren Säuglinge" was published in the *Central Zeitung für Kinderheilkunde* (October, 1878, p. 3); also in the *Archiv für Kinderheilkunde* (1880, p. 53).

Ritter died on Aug. 20, 1883.

RIVALTA'S DISEASE: *Actinomycosis.*

Sebastain Rivalta was an Italian veterinarian.

Fig. 36.—A. Maurice Raynaud (after J. M. Soc., New Jersey).

ROBINSON'S DISEASE: *Hydrocystoma.*

Andrew Rose Robinson was born on July 31, 1845, at Claude, Ontario, Canada. He studied at Toronto, New York, Paris, Vienna, London and Edinburgh. He was prize essayist at Bellevue Hospital Medical Alumni, 1877. He practices dermatology in the city of New York. The disease given his name was described in Robinson's "Manual of Dermatology" (1884, p. 84; *J. Cutan. Dis.* **2:** 362, 1884; **11:** 293, 1893). Robinson is a member of the American Dermatological Association and was its president from 1890 to 1891.

ROLLETT'S DISEASE: *Mixed chancre.*

Joseph Pierre Rollett was born at Lagnier in 1824. He made the distinct advance of recognizing the possibility of mixed infection of one sore with syphilis and chancroid. This made the dualistic theory of such venereal infections. These texts are accredited to Rollett: "De la

pluralite des maladies venerienne" (Paris, 1858), "Recherches cliniques et experimentales sur la syphilis" (Paris, 1861) and "Traite des maladies vénériennes" (1866). He died on Aug. 2, 1894, on the day of the opening of a dermatologic congress at which he was to have presided.

ROSENBACH'S (DISEASE) ERYSIPELOID.

Anton Julius Friederick Rosenbach was born at Göttingen, Germany, on Dec. 16, 1842. He studied at Heidelberg, Göttingen, Vienna, Paris and Berlin. His major interests were surgery and pathology. The disease most frequently known as "erysipiloid of Rosenbach" was probably first clearly described by Morrant Baker as "erythema

Fig. 37.—Frederick von Recklinghausen (after Galerie hervorrangender Arzte).

serpens." It was investigated clinically and bacteriologically by Rosenbach, "Ueber das Erysipiloid" (*Arch. f. klin. chir.* **36:** 346, 1887) "Ueber die Erzeugung locale und allgemeine Tuberculose durch Einimpfen fungoser Producte und chronische Eiterungen zum Beweis der Tubercle natur dieser Erkrankungen" (*Verhandl. d. Deutsch. Gesell. f. Chir.*, Tenth Congress, 1881; Trans. **16:** 75, 1887) was another contribution from this authority.

SAVILL'S DISEASE: *Dermatitis exfoliativa epidemica.*

Thomas Dixon Savill was born in England in 1856. The condition named after him is described in a number of articles (*Brit. M. J.* **2:** 207, 1891; **1:** 56, 1892; **4**: 35, and 69, 1892; **1**: 1431, 1894; *J. Cutan. Dis.* **12:** 281, 329, 1894). A monograph published in London in 1892 under the title of "Epidemic Disease Resembling Eczema and Pityriasis Rubra" contained numerous illustrations.

Savill was a distinguished student, gaining many prizes and recognition for his brilliancy. He studied in England, at Paris, Vienna and Hamburg. He was an executive of marked ability in all Poor Law Commissions; he published a text on clinical medicine in two volumes (1903-1905) and numerous articles on pathology and nervous system diseases.

Savill died at Algiers, on Jan. 10, 1910, from a fracture of the base of the skull caused by a fall from his horse (*Lancet*, Jan. 15, 1910).

SCHAMBERG'S DISEASE: *Peculiar progressive pigmentary disease.*

Jay Frank Schamberg was born in Philadelphia, on Nov. 6, 1870. He is identified with dermatology in his own city, Philadelphia, where he has been professor of skin diseases. He is a member of the American Dermatological Association, and was its president from 1920 to 1921. The disease to which his name is given was first described in the *British Journal of Dermatology* (**13:** 1, 1901). Schamberg has been most

Fig. 38.—Julius Rosenbach (after Pagel).

interested in seeking the etiology of psoriasis, and numerous references are given to his reports in this field (*J. Cutan. Dis.* **31:** 697 and 802, 1913; **33:** 819, 1915; **33:** 1 and 98, 1915; *J. A. M. A.* **63:** 729, 1914).

America and probably the world owes a great debt to Schamberg for his independent activities in supplying arsphenamin to civilian and military communities during the World War when the German supply to the allies was not forthcoming.

Schamberg is the author of a "Compend of Diseases of the Skin," a text on "Diseases of the Skin and Eruptive Fevers" and the co-author with Welsh of "Acute Contagious Diseases."

Schamberg described "Grain-Itch (acaro-dermatitis urticariodes) as a Study of a New Disease in This Country" (*J. Cutan. Dis.* **28:** 67, 1910; Govt. Printing Office, 1909).

SCHENCK'S DISEASE: *Sporotrichosis.*

Benjamin R. Schenck reported "On Refractory Subcutaneous Abscesses Caused by a Fungus Possibly Related to Sporotrichosis" (*Johns Hopkins Hosp. Bull.* **9:** 286, 1898).

SCHOENLEIN'S DISEASE: *Purpura rheumatica.*

Johann Lucas Schoenlein was born in Germany on Nov. 30, 1793. He was the first to lecture in German instead of Latin (1840). The disease named after him is described in several papers (*Allg. u. Spec. Path. u. Therap.* **2:** 1848, 1837). Schoenlein disclosed *Achorion schoenleinii* and described the discovery in a communication only twenty lines long (*Müller's Arch.*, 1839, p. 82). The achorion was independently discovered by Gruby in 1841. R. Remak credited the name to Schoenlein, "Diagnostische u. pathogenetische Untersuchungen in der Klinik des H. G. R. Dr. Schoenlein auf dessen Veranlausung ausgestellt" (Berlin, 1845). Schoenlein also contributed to the study of typhoid fever and to clinical favus. He was the author of several texts on pathology.

Schoenlein died in 1864.

Fig. 39.—Johann Schoenlein (after Garrison).

TAENZER'S DISEASE: *Ulerythema ophryogenes.*

P. Taenzer published a study under the title of "Ueber das Ulerythema ophyrogenes eine noch nicht beschriebene Hautkrankheit" (*Monatschr.* **8:** 197, 1889). The name was suggested by Unna. Taenzer was also associated with Unna in the discovery of orcein as a specific stain for elastic tissue. He also wrote on the treatment of blennorrhea and on soaps. Taenzer was co-author with Unna of "Acute Exantheme" (Berlin, 1895).

TAYLOR'S DISEASE: *Idiopathic progressive atrophy of the skin.*

Robert William Taylor was born at Coventry, England, on Aug. 11, 1842. He came to the United States in 1850. He became a drug clerk; he then entered the office of Willard Parker. He became clinical professor of genito-urinary diseases at the College of Physicians and Surgeons, New York City, and professor of dermatology at the University of Vermont. He wrote numerous articles on skin and venereal

disease, and was associated with Freeman J. Bumstead in preparing a textbook and clinical atlas. Taylor was a founder of the New York Dermatological Society, as well as of the American Dermatological Association. He was a ready writer. He wrote an article "On a Rare Form of Idiopathic Localised or Partial Atrophy of the Skin (*Arch. Dermat.* **2:** 114, 1876).

Taylor died on Jan. 4, 1908.

UNDERWOOD'S DISEASE: *Scleroma neonatorum.*

Michael Underwood was born in 1737. He was a London pediatrician. This disease was first called "hidebound," and its description may be found in Underwood's "Diseases of Children" (1784, p. 76). Until 1877, this disease was mistaken for "edema neonatorum." Parrot

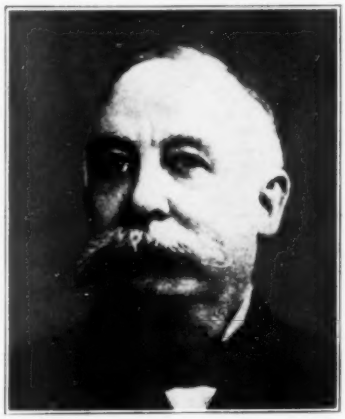

Fig. 40.—Robert W. Taylor (after American Dermatological Association portraits).

drew the distinction between the two diseases (Clinique des nouveaux l'Athrepsie, 1887, p. 116).

The first known case of scleroma neonatorum occurred in Stockholm Hospital in 1718, and is recorded by Usenberigens of Ulm (Partus Octimestris vivus Frigidus et Rigidus, *Ephemerid. Acid. naturae cur. centuria* **9:** 62 [Dec.] 1722, obs. 30).

UNNA'S DISEASE: *Seborrheic dermatitis.*

Paul Gerson Unna was born in Hamburg, Germany, on Sept. 8, 1850. He is the son of a physician. He was educated at Heidelberg, Leipzig and Strassburg. In 1884, he began to specialize in dermatology. He is recognized as the master of histology and histopathology of the skin. He is accredited with having put the study of skin diseases on a microscopic analytical basis. Unna's studies are far too numerous to

detail. The disease which has been given his name was reported by Unna as "Das Seborrhoische Eczema" (*Monatschr.* **6:** 71, 1887) and as "Seborrheal Eczema" (*J. Cutan. Dis.* **5:** 449, 1887 and Volkmann's *klin. Vort.*, Sept., 1893, No. 79). Unna's histologic and histopathologic investigations included specific staining reactions and bacteriologic studies (*Monatschr. f. prakt. Dermat.* **2:** 217, 1883; **5:** 243, 1886; **7:** 718, 1888), "Histotechnic der leprosen Haut," 1910. He studied the development of the nail; divided the stratum corneum into four layers (*Arch. f. mikr. Anat.* **12:** 665, 1876), described the "balloon cells" of herpes zoster, as well as giant cell formation, reticulation of vesicles and bullae resulting from thermal irritation. He revealed twenty-three varieties of cocci in eczema (*Monatschr.* **29:** 231, 1899). He studied the bacteria associated with acne, impetigo, alopecia areata,

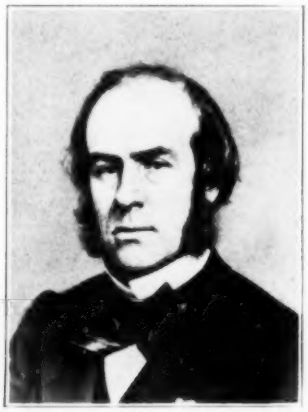

Fig. 41.—Emil Vidal (after Collection of Academy of Medicine, New York).

piedra nostras, soft chancre (Unna-Ducréy bacillus) as well as the organisms of tinea. He advanced the morococcus as the cause of infection of the epidermis in seborrheic eczema. His clinical studies included those of the Harlequin fetus, herpes progenitalis in women, lichen rubra, Duhring's disease, urticaria simplex, urticaria pigmentosa (mast cells), keratoma plantaris et palmaris; ulerythema (with Taenzer), pemphigus vulgaris, hydroa puerorum and eczema. He initiated the study of diseases of the skin by means of diascopy, 1893. He was a master of histotherapy and dermatotherapy. His monument will be "Die Histopathologie der Hautkrankheiten," 1894 (English edition translated by Norman Walker). "Histologischen Atlas zur pathologie der Haut" was published and "Die praxis der Hautkrankheiten," 1908. Unna was co-editor of the "International Atlas seltener Hautkrankheiten." Since retiring from active practice, Unna has devoted himself to the study of microchemical research.

VIDAL'S DISEASE: *Lichen chronicus simplex.*

J. B. Emile Vidal was born in Paris, France, 1825. He was an exceptional student of dermatology, and from his numerous contributions to its literature we mention: discovery of parasite in pityriasis rosea (*Ann.*, 1882, p. 22), eczema of adjoining mucous surfaces (*Gaz. d. hôp.*, 1880, p. 68); sections of wheal of urticaria (*L'Union Med.*, 1880, Feb. 24) and keratosis blennorrhagica, which Vidal was the first to describe (*Ann.*, 1893, p. 3).

Brocq and Jacquet wrote, "Notes pour servir a l'histoire des nevrodermitis; du lichen circumscriptus des anciens auteurs, ou lichen simplex chronique de M. le Dr. E. Vidal" (*Ann.* **2**: 97, 1891).

Vidal published "De la syphilis congenitale," (Paris, 1860), and was co-author of "Traite descriptif des maladies de la peau, symptomatologie et anatomie pathologique," 1889.

Fig. 42.—Paul Werlhoff (after Garrison).

Vidal was an honorary member of the American Dermatological Association. He died on June 16, 1893.

VOLKMANN'S DISEASE: *Cheilitis glandularis.*

Richard von Volkmann was born in Leipzig on Aug. 17, 1830. He was a surgeon of highest attainments. In addition to the description of the disease mentioned above, he is accredited with the first description of tar and paraffin cancer (Beitr. z. Chir., 1875, p. 380).

Volkmann died at Jena, on Nov. 28, 1889.

WAGNER'S DISEASE: *Colloid milium.*

Ernest Wagner was born in 1829, and died in 1888. He wrote a description of "Das Colloid" (*Arch. der Heilk.* **7**: 463, 1866).

WERLHOFF'S DISEASE: *Purpura hemorrhagica; morbus maculosus.*

Paul Gottlieb Werlhoff was born in Germany in 1699, and died on July 26, 1767. He was studious, a good observer, a talented physician, a recognized teacher and a writer. The reference we have is *Opera Omnia Hannover* (**2:** 615, 1775) and a Dissertation (Brunswick, 1735).

WESTBERG'S DISEASE: *White spot disease.*

Frederick Westberg was a German who described, "Ein Fall von mitt Weisen Flecken einherzehinden bisher nicht bekannten Dermatose" (*Monatschr.* **33:** 355, 1901).

WHITE'S DISEASE: *Keratosis follicularis.*

James Clarke White was born in Belfast, Me., on July 7, 1833. He studied in Vienna. He was the pioneer dermatologist of Boston. He

Fig. 43.—James Clark White (after American Dermatological Association portraits).

was the first professor of dermatology in the United States, Harvard Medical School. He was the first president of the American Dermatological Association, and president of the sixth international dermatology congress in New York, 1907. White and Darier independently described the disease which has variously been known by each of their names, but predominantly by that of Darier's. White's paper was on "Keratosis follicularis" (*Am. J. Cutan.* **7:** 201, 1889; **8:** 13, 1890). White made many great advances in the practice as well as the teaching of dermatology. He wrote a paper on "The Old Age of the Skin" (*Boston M. & S. J.* **107:** 484, 1882). White's monograph on dermatitis venenata remains classic (Boston, 1887). He was the author of numerous monographs on dermatology ("Sketches from My Life,"

1833-1913, with bibliography "In Memoriam, James Clarke White," *Brit. J. Dermat.* **28:** 1, 1916).

WILKS' DISEASE: *Verruca necrogenica.*

Sir Samuel Wilks was born on June 2, 1824, and died in 1911. The reference to the disease associated with his name was described as "Disease Produced by Postmortem Examination" (*Guy's Hosp. Rept.* **35:** 263, 1862). Darier notes that verruca necrogenica was described by Laennec. Wilks also wrote "On Markings or Furrows on the Nails as the Result of Illness" (*Lancet* **1:** 5, 1869). He wrote a description of some wax models illustrating a peculiar atrophy of the skin, etc. (*Guy's Hosp. Rept.* **7:** 297, 1861); Wale: Bibliography of the Published Writings of Sir Samuel Wilks (*Guy's Hosp. Gaz.*, Nov. 25, 1911).

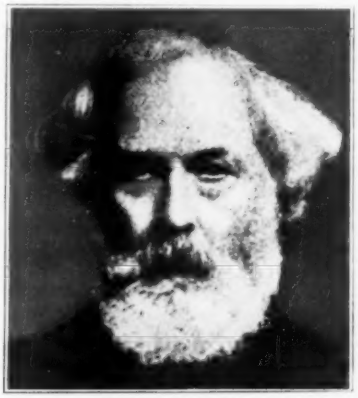

Fig. 44.—Samuel Wilks (after Garrison).

WILLAN'S LEPROSY: *Psoriasis.*

Robert Willan was born in 1757 and died in 1812. He was an English Quaker. He has been variously called the creator of dermatology and perhaps more truthfully, the initiator of a new era in dermatology and founder of the modern epoch in skin diseases. The history of dermatology may well begin at this period of Willan. He gave the first valuable classification of skin diseases, and was the first to attempt a complete classification. Willan followed Plenck's system. Plenck's Doctrina de morbis cutaneis (1783; German, 1789) divided diseases of the skin according to the form of their pathologic products. Willan's system may be found, "On Cutaneous Diseases," 1808, and "Arrangement of the Disease of the Skin," in Cullen, "Synopsis of Nosology" (London, 1828, pp. 141 to 151). Willan was famous for his judicious selection and accurate definition of terms. He extricated

psoriasis from the heterogeneous group of skin diseases. He divided the purpuras into simplex and hemorrhagic. He cleared up the nature of eczema for his time, and distinguished lupus from other dermatoses, hence, Willan's lupus. He distinguished tinea versicolor from the other pigmentary diseases. He gave the original descriptions of prurigo (mitis), ichthyosis and pityriasis (Practical Treatise on Porrigo or Scalled Head and on Impetigo, etc., edited by Smith, 1814). Willan did not complete his work "On Cutaneous Diseases" (1796 to 1808, vols. 1 to 4) (later translated into German), but his student and successor was responsible for "Practical Synopsis of Cutaneous Diseases According to the Arrangement of Dr. Willan" (London, 1815). Willan and Bateman were accredited jointly for the description of herpes iris (Bateman's disease) (Delineation of Cutaneous Diseases, 1817). These

Fig. 45.—Erasmus Wilson (Contemporary Medical Men).

co-workers were accredited with describing five varieties of impetigo: figurata, sparsa, scabida, erysipea-latoides and rodens. The first four, according to Crocker, were probably eczematous, or impetigo contagiosa, the last probably tertiary syphilis or rodent ulcer. Under the name of ichthyosis cornea, Willan quotes the first known case of scleroderma, that of Curcia of Naples, 1752.

WILSON'S DISEASE: *Lichen planus.*

Sir William Erasmus Wilson was born in England in 1809. He studied at St. Bartholomew's Hospital. He was an assistant of Quain. He became a Fellow of the Royal College of Surgeons in 1831. In 1842, Wilson published his lectures on skin diseases, and these have had numerous English and French editions. He was the author of a dissecting manual and a set of anatomical plates. He began the *Journal of Cutaneous Medicine and Diseases of the Skin.* He prepared a

museum of cutaneous preparations. He made many advances, especially in the parasitic diseases of the skin. His paper on lichen planus was published in the *Journal of Cutaneous Medicine* (3, No. 10, 1869). Wilson was the first to describe dermatitis exfoliativa (Wilson's disease). He described erythema nodosum in his work, "Diseases of the Skin," 1857. He studied xanthoma or xanthelasma (E. Wilson), called vitiligoidea by Addison and Gull (1851). Wilson classified the diseases of the skin on a thoroughly anatomical basis. His scheme did not meet with general favor.

Wilson made an estimate as to the number of hairs on the scalp as 100,000. He described trichorrhexis nodosa as trichoclasis in 1849. This was later described by Beigel and Kaposi.

Wilson's work was a landmark in the history of the English school of dermatology. He did much to popularize the specialty. He was an honorary member of the American Dermatological Association. He was recognized as a brilliant and versatile leader among the profession in London.

Wilson died on Aug. 8, 1884.

WINKLER'S DISEASE: *Chondrodermatitis nodularis chronica helicis.*

The reference to this disease is *Archiv für Dermatologie*, volume 125, page 278.

W. B. Saunders Company, in the absence of Dr. Garrison, have kindly given me written permission to copy the photographs. The Collections of the Academy of Medicine, New York City, the Library of the College of Physicians and Surgeons, New York, and that of the College of Physicians, Philadelphia, were kindly placed at my disposal by Mrs. Smith, Mr. Roberts and Mr. Fisher respectively.

PRECISION IN DERMATOLOGIC ROENTGEN THERAPY

THE VALUE OF RECENT REFINEMENTS IN APPARATUS: PRELIMINARY REPORT *

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PORTLAND, ORE.

Ever since the experimental therapeutic use of the roentgen ray was stimulated by the recognition of its occasional accidental, associated action on cutaneous structures, the medical press has constantly contained a generous literature describing the therapeutic value of the agent and the proper methods of its application. For many years there were almost as many technics of application and measurement as there were operators, with the result that the popularity of the agent was as fluctuating as were the results obtained from its usage. As is the history with many discoveries, out of the confusion that first clouds true values there emerged a general principle which, if conscientiously adhered to and tempered by judgment and experience, brought about a fair percentage of favorable results. Thus, while indefinite in many respects, the so-called fractional method of treatment for many years was the recognized technic. Briefly, this method was one by which maximum effects were gradually obtained by the administration of small doses, repeated at short intervals, and continued over a long period of time. Somewhat later, results favorably comparable to the foregoing were obtained by adherence to a principle differing radically from the preceding. By the later method, the maximum effect of the rays was obtained at one sitting and the dose not repeated for an extended period. To this technic the term "massive dosage" has been given. With this growing tendency toward larger dosage, an increasing demand for greater accuracy of estimation arose. It would now seem one has at his disposal a method meeting these requirements—that of MacKee's mathematical estimation of roentgen-ray dosage. In spite of this epoch-marking work, one still hears voiced by others, or meets in his own experience, an occasional variation in expected clinical results, for which mathematical factors cannot be called to account.

Heretofore, such variable factors as tissue tolerance, individual susceptibility, age, complexion, and especially idiosyncrasy, have been the explanations offered for the foregoing variations. However, treatment governed by the application of available and established facts has apparently fairly satisfactorily overcome most of these influences.

* From the Department of Dermatology and Syphilology, University of Oregon Medical School.

Regarding the exact status and definite influence of idiosyncrasy, the literature of those most experienced in the work reveals a significant variance of opinion. With the development of the new short-ray therapy, special apparatus, theoretically more accurate, has become available. Incidental to the use of this apparatus, possible mechanical inaccuracies of previous apparatus have been revealed, over which mathematical formulas have no control. It is on the possible influence of such a factor that the present study has been undertaken.

During the practical and scientific investigations following Roentgen's original communication, an increasing interest centered about the development of new exciting apparatus and instruments of precision or of measurement. As a result of this work, it was the custom for a number of years to estimate the quantity of radiation affecting a given tissue mass by establishing various so-called constants. These included milliamperage, spark gap, number of interruptions per second, distance from anode to skin, etc. Before the present degree of perfection was attained in tubes and transformers, this was a difficult and even hazardous procedure; so much so in fact that a feeling of dissatisfaction existed generally. With Kienbock's work establishing the law that "the degree of reaction depends upon the quantity of X-ray absorbed by the skin," and later a law stating that "the intensity of the rays varies inversely as the square of the distance," the so-called direct method of measurement of quantity was developed. This was accompanied by Holzknecht's announcement of the chromoradiometer in 1902. The original instrument was not a success, and was soon withdrawn from the market. The principle, however, modified by various workers and applied to different instruments still exists as the direct method of dosage measurement, applied by either the photographic or chemical method.

Parallel with, and even preceding, this progress, there developed a so-called indirect method of measurement. As before mentioned, this estimation depended for its accuracy on the factors of voltage, milliamperage, time and distance. In the beginning it proved so unreliable that it soon gave way to the direct technic. With the advent of the interrupterless transformer and the Coolidge tube, however, the practicability and flexibility of the method rapidly became so evident that it soon reached, and has since maintained, an application perhaps more universal than that of the method by which it was formerly replaced.

With a proper appreciation and a practical method of simple arithmetical computation, it appeared that little was left to be desired, providing the foregoing factors of milliamperage, voltage, time and distance were always and invariably to be relied on as constants during any given operation. Naturally, the possibility of variation in the factors of time and distance is obviated. In the past, fluctuations in

clinical results seemed more easily explained on the basis of individual variation rather than by any possible change in the value of factors of milliamperage and voltage. Regarding the former, one has only to watch the dial of the meter in many cases to see how rarely it is at rest; while up to the present the estimation of voltage has seemed satisfac-

Fig. 1.—Left, erythema dose, spark gap estimation; right, erythema dose, sphere gap estimation. These reactions developed simultaneously and remained practically equivalent throughout the period of treatment

torily accomplished by the point spark gap. An investigation of the recognized standard requirements for this instrument is of interest. It is to be noted that it should be equipped with needle points; that these should be changed after each spark over; and that they should be approximated in a very definite manner. Finally, it is also to be

noted that even under such conditions the readings may be influenced by temperature, humidity, altitude and surrounding objects. Furthermore, given the standard conditions, it seems to be the consensus of technical opinion that the reliability of the instrument is subject to serious question above a potential of 50,000 volts. It is thus to be seen that the instrument on the ordinary machine falls far short of these requirements; that there may well be wide variations in machines of the same and different manufacutres. In proof of such theoretical considerations, Ullmann,[1] using the ordinary point gap, was able to show kilovolt fluctuations as high as 30 per cent., occurring with equivalent factors, but applied to different machines. If such voltage variations are possible with the point gap, it seems not unusual that unexpected clinical results may well occur with an explanation of voltage fluctuation as applicable as those hitherto offered.

As a result of this lack of uniformity in testing results from various laboratories, and a growing realization of the possible causes of error in the point gap method of estimation, especially with high voltages, electrical engineers have rather recently developed an instrument known as the sphere gap. This likewise is required to meet certain standards of construction, but apparently these standards are fairly easily satisfied, even under conditions of office or institutional practice. In addition, the corona discharge, and the influence of humidity, altitude, etc., apparently objections to the point gap, are to a large extent avoided. In other words, theoretically at least, the sphere gap would seem to be an instrument available for practical purposes and capable of giving us accurate information regarding one of the dosage factors which are so essential to constant clinical results. In addition, the fluctuations in the milliamperage may now be satisfactorily controlled by the so-called stabilizer. With these two improvements at our disposal, it would appear that previous possible variations in dosage factors were, to a large extent, eliminated, and that by their usage more constant clinical results might be predicted and obtained.

For this preliminary work, twenty-six persons have been used, the exposures being made purely experimentally, and not for the treatment of any existent disease condition. These persons were chosen at random from dispensary material, without reference to age, sex, complexion, etc. In other words, an attempt was made to imitate an ordinary office

1. Ullmann, H. J.: Am. J. Roentgenol. **8**:195; American Institute of Electrical Engineers Standard, 1922, pp. 20 to 23. Farnsworth, F. W., and Fortescue, C. L.: The Sphere Gap, Tr. A. I. E. E. **32**:733 to 737, Pt. 1. Chubb, W. L., and Fortescue, C. L.: Tr. A. I. E. E., **32**, Pt. 1. Peek, F. W.; Skinner, C. E.; Sandsford, Jr., J. A.; Steinmetz, C. P., and Others: Discussions, Tr. A. I. E. E. **32**, Pt. 1. Peek, F. W.: Dielectric Phenomena in High Voltage Engineering, pp. 87 to 116.

Fig. 2A

Fig. 2B

Fig. 2.—Left, erythema dose, spark gap estimation; right, erythema dose, sphere gap estimation. *A*, eight days following exposure. Note absence of reaction on left. *B*, slight reaction on left after fourteen days. Present at eight days on right.

or dispensary practice, and at the same time to provide opportunity for influence of individual variation. For the most part, each person received multiple exposures, with two sets of factors: $\frac{6sp\ 2ma\ 3t}{8d}$ and $\frac{6sp\ 4ma\ 1\frac{1}{2}t.}{8d}$. In every instance the stabilizer was used. All exposures were made in parallel, and so far as possible all conditions were identical, except that of voltage estimation. In one series the point gap was used, in the other the equivalent kilovoltage as measured by the sphere gap. The patients were observed usually at from three to four day intervals. Because of the outstanding features, and because the work is still under progress, the results only at certain intervals are included.

The intervals arbitrarily chosen for observation were the seven and eight day period and the fourteen day period; that is, the presence or absence of definite color change at these intervals following exposure formed the basis of the readings enumerated below. This, in the first place, excluded the complications of the early so-called "electric reaction" sometimes observed, and at the same time excluded those reactions delayed longer than the usual time between exposure and physical response. No case was included in one group or the other unless a definite color change was present. If the presence of such a change was still questionable at the tenth day, but present at the fourteenth, the result was included in the latter group.

Observed with these points in mind, it was found that certain cases reacted definitely at the end of one or both intervals following exposure. These were clear-cut reactions and were classed as positives. The second group of cases, as would be expected, reacted doubtfully at the end of the first period, but these cases were easily classed as definite reactions at the fourteenth day. The third group were indefinite throughout, and so far as clinical results might be concerned, were considered negative. Finally, some developed only the faintest possible change at the fourteenth day. Adhering to these criteria, it was found that out of the total, or twenty-six cases, receiving an erythema dose as estimated by the point gap, only twenty-one, or approximately 81 per cent., presented the expected clinical reaction at the end of the usual seven to ten day period. Following this group through, one case that had only the faintest suggestion previously, at the fourteenth day presented sufficient color change, making a total of 22 or 85 per cent. In addition, however, an interesting occurrence became manifest in that one of the patients who had a strongly positive reaction at the seventh day, at the end of the fourteenth day presented a distinct dermatitis. The fact that this occurred, in spite of personal supervision and every precaution, is at least suggestive of certain possibilities. The remaining four cases, incidentally of various ages, showed no visible color

change throughout the period of observation. In other words, the expected clinical results were obtained in only 85 per cent. of the cases treated, in spite of most conscientious attention to the factors on which the dosage was based.

Passing to the reactions resulting from the use of the sphere gap, it was found that observation during the seven to ten day period revealed twenty-four, or 93 per cent., who presented definite reactions. The remaining two were suggestive, but could not be included, although four days later one of these assumed the appearance of a definite erythema. In other words, the percentage of positive results resulting

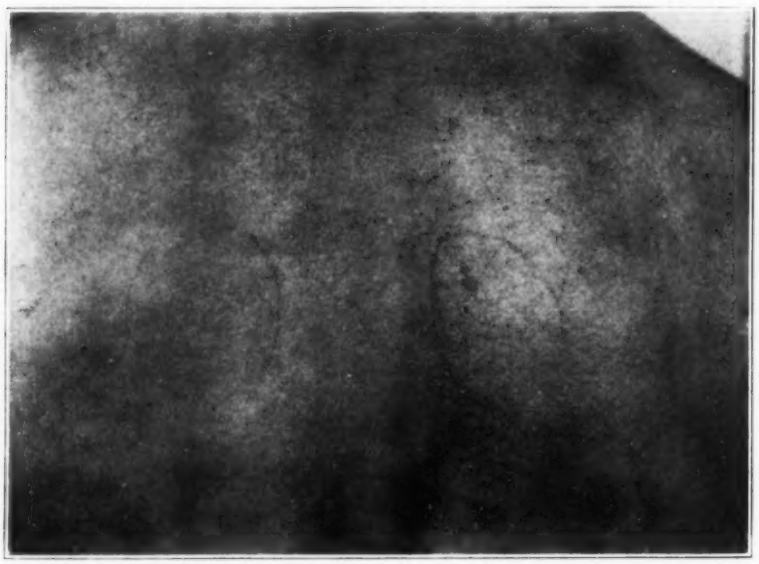

Fig. 3.—Left, erythema dose, sphere gap estimation; right, erythema dose, spark gap estimation. Note absence of reaction on right fourteen days after exposure, while definite reaction is present on the left

from the use of the sphere gap at the end of the fourteenth day was 96. What would seem to be even more important, however, was that the type of reaction was decidedly more constant, better defined, and subject to much less question than the varying degrees observed in the former cases. The accompanying Figures 1, 2 and 3 show some of the variations observed. In brief, then, it was found, under the conditions of the foregoing experiment, that certain variations are possible, even though the factors on which we are accustomed to depend were as constant as personal care could make them. Further, while neither method is without fluctuation, the use of the sphere gap apparently makes possible a decidedly higher percentage of positive experimental

clinical results and a gratifying steadiness. While a similar series of clinical experiments on various apparatus might well not give parallel results, the laboratory findings of Ullmann and the clinical findings herein given, indicative of the possible advantage of the sphere gap in its relation to clinical effects, make for its more universal application. By such universal application, the present objections to certain methods might well be obviated, and a country wide standardization of technic made possible. The lack of such a standardization unfortunately has seriously handicapped the progress of an agent which has, and still does, receive much undeserved criticism, but to which is due an unquestioned place in modern therapeutics.

SUMMARY AND COMMENT

It may be seen that the alternating periods of optimism and pessimism through which the roentgen ray has passed have been largely due to the relative accuracy of particular methods of control in vogue at a given time. In the beginning, there was the rational theory that the extent of the biologic effects of this unusual form of energy should be predicted by a proper estimation of certain factors. Because of mechanical imperfections, the method was for a time replaced by photographic and chemical procedures. It was soon found, however, that even this method required a personal expertness in the judgment of rather fleeting color changes, which made the method practicable only for those with a properly directed and unusual experience. With greater perfection in apparatus, the older method again assumed the place of choice. Depending, as it does, on the factors of milliamperage, voltage, distance and time, and based on the knowledge that these may be mathematically computed, it leaves little to be desired and finds easy and practical application in the ordinary busy routine. An explanation of many of the present variations and disappointing results, it would seem, must be sought rather in mechanical details of construction than in present methods of dosage estimation. In the foregoing, it is hoped one important source of such errors is established, and a practical method of its elimination suggested.

CONCLUSIONS

1. Under the conditions of the foregoing experiment, variations in voltage estimation may, and do, occur, of sufficient magnitude to cause corresponding variations in clinical reactions.

2. The possibility of variations such as the foregoing is apparently lessened by kilovolt estimation, using the sphere gap.

3. The foregoing method of kilovolt estimation applied to formulas herein discussed is suggested as a step toward a more satisfactory standardization in our present technic.

URTICARIA PIGMENTOSA IN ADULTS TREATED BY THE ROENTGEN RAY

REPORT OF A CASE

JEFFREY C. MICHAEL, M.D.
HOUSTON, TEXAS

In February, 1923, Howard Fox [1] presented an adult patient who had urticaria pigmentosa, who had been treated with the roentgen ray with considerable benefit. To determine the effect of treatment, Fox at first treated his patient on one side of the body only, but evidently irradiated the remaining lesions subsequently, as he reported [2] having had a case which was entirely cleared by the roentgen ray. Presumably, this was the same case that was exhibited in New York.

MacKee [3] records two cases from the literature treated by the roentgen ray—those of Török and Scheim of Jacob. Török and Schein's patient, according to the original article, was 25 years old and presented a typical outbreak on the trunk and extremities. A palm sized area on the flexor surface of the right elbow was irradiated until a reaction was produced. The lesions disappeared from this area. Jacob's original report could not be obtained, but according to MacKee, the eruption did not disappear, although the itching and factitious urticaria did. These symptoms returned in three months, and were again relieved by irradiation; but the final outcome of the case was unknown.

These are the only recorded cases of urticaria pigmentosa treated by the roentgen ray that could be found by a reasonably thorough search of the literature. None of the dermatologic texts mention the roentgen ray in the treatment of this disease, and none offer much benefit from the medication that they advise. Therefore, it seems worth while to record the effect of the roentgen ray in a case of this disease which was cleared up entirely by this means, but which now, one year after the last treatment, presents returning lesions.

REPORT OF A CASE

History.—I. F., aged 33, a banker, was referred on Jan. 11, 1922, by Dr. Gavin Hamilton of this city. The patient consulted Dr. Hamilton because of an eruption and a rather indefinite digestive disturbance.

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1. Fox, H.: Urticaria Pigmentosa Treated by the Roentgen Ray, Arch. Dermat. & Syph. **7**:273 (Feb.) 1923.

2. Fox, H., in discussion of case of "Lichen Ruber Planus" presented by Dr. Wile, Arch. Dermat. & Syph. **8**:863 (Dec.) 1923.

3. MacKee, G. M.: X-Rays and Radium in the Treatment of Diseases of the Skin, Philadelphia, Lea & Febiger, 1921, p. 553.

Fig. 1.—Condition in January, 1922, before treatment. Two lesions below the right nipple show the pronounced factitious dermographia that could be elicited.

With the exception that both parents were dead, the father as a result of apoplexy, and the mother from nephritis, the family history contained nothing of moment. The patient's appendix was removed in 1914. In 1910, he had a chancre, followed by an eruption confined to the legs. A Wassermann reaction was positive at that time. He was treated with arsphenamin and mercury, but rather desultorily, and inadequately according to present day practice. Since 1912, he had had pyrosis and nausea for several months at a time. Dr.

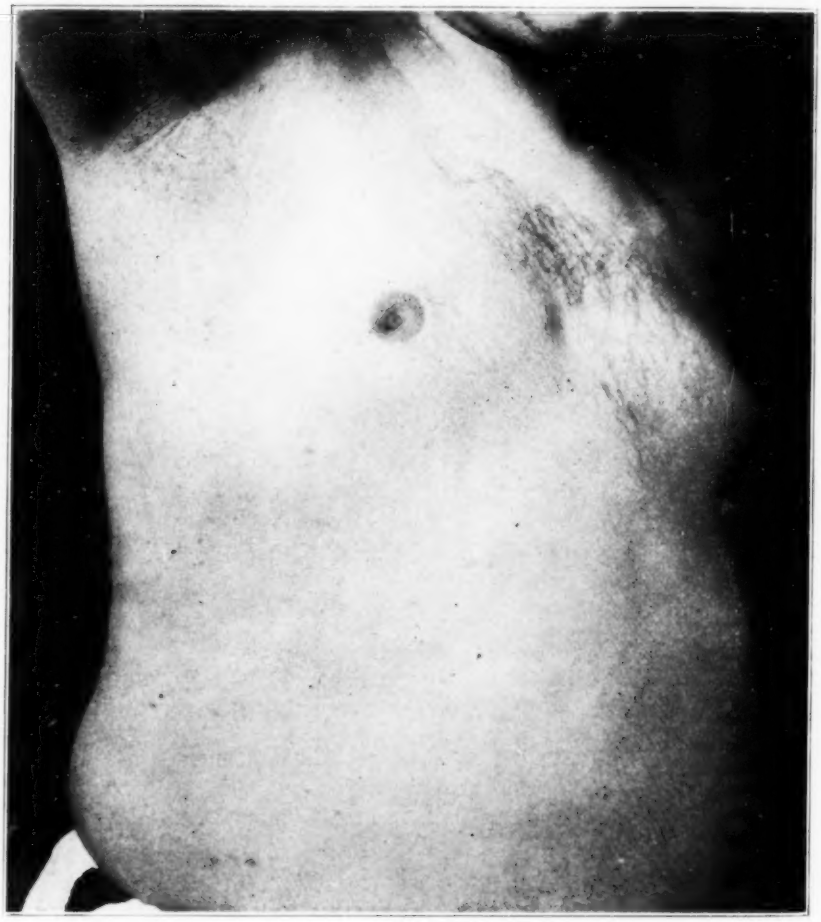

Fig. 2.—Condition in February, 1923, after treatment was completed. Nothing remains but a few light colored stains, which are not demographic.

Hamilton had been treating him for these symptoms, but the patient had refused some of the laboratory examinations which were indicated.

The skin disease began two years before, first on the abdomen, then on the legs, arms, hands and face. Its progress was slow but steady. It was unattended by subjective symptoms, and occasioned no concern until it appeared on the exposed parts. About six months after its appearance, he was given one dose

of arsphenamin. This seemed to cause a more rapid spread of the lesions and to deepen the color of those already present.

Physical Examination.—This revealed a stout man with a fleshy musculature. The cutaneous surface was spotted with an eruption which will be described in detail. The heart and lungs were apparently normal. The liver could be felt one finger-width below the costal arch. There was a bilateral epitrochlear adenopathy. The pulse rate was 78. The blood pressure was: systolic, 102; diastolic, 68. Routine blood examination and urinalysis were negative. A Wassermann reaction was negative.

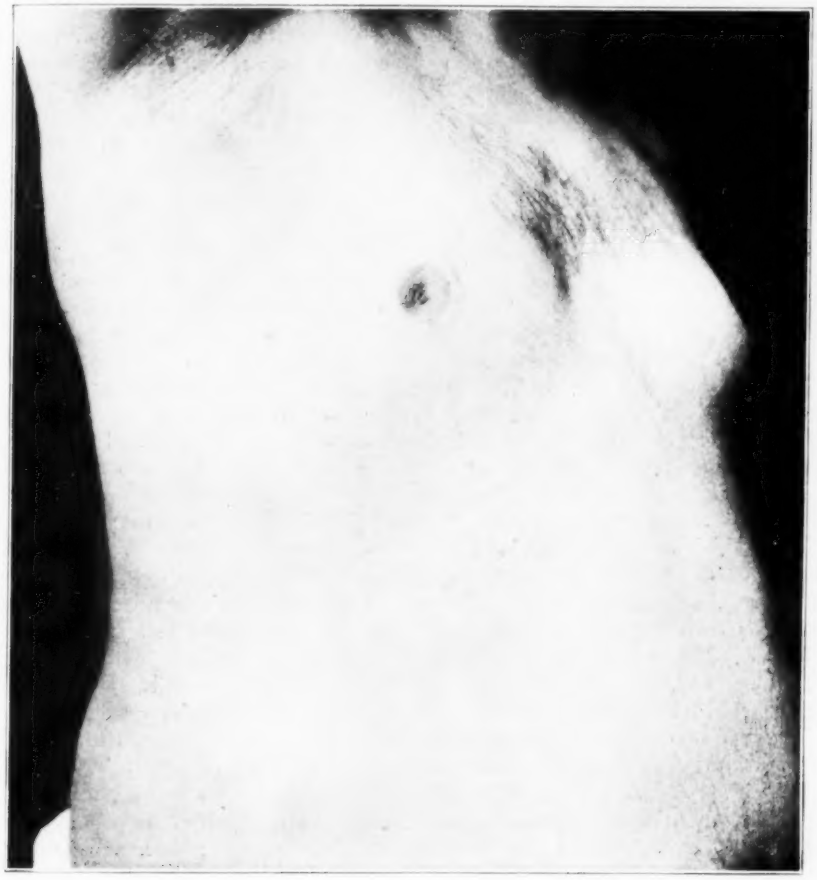

Fig. 3.—Condition in January, 1924. The area is entirely free from the disease, with the exception of three lesions which have appeared recently.

Because of a persistently low systolic pressure, the patient was given a suprarenalin test for hypo-adrenalism. Three minims (0.18 c.c.) intravenously raised the systolic blood pressure from 100 to 118. The test was interpreted as negative.

The eruption was generalized. It was more profuse on the face and neck than elsewhere. The lesions were scattered in an irregular fashion on the

cutaneous surface, except that they followed the lines of the ribs on the back and sides of the thorax. The lesions were oval macules or slightly raised, dome shaped papules, of moderately firm consistence and deep brown. In size they were from 5 to 7 mm. in their longest diameter. Rubbing the lesions caused a pronounced factitious wheal formation (Fig. 1). The unaffected skin, however, presented no dermographia. There were no subjective symptoms.

The patient was unable to take treatment when first seen, but he returned in April, 1922. At that time a biopsy was performed, and during that month he was presented at a meeting of the Texas Dermatological Association, the visiting members agreeing with the diagnosis. He was again presented in March, 1923, to show the effect of treatment.

The essential feature of the pathologic picture was a moderate infiltration in the papillary body and about the vessels of the subpapillary plexus composed principally of small round cells with a few epithelioid and mast cells. The latter were in somewhat larger numbers than are commonly present in chronic inflammatory processes, but with nothing of the frequency or arrangement recorded in urticaria pigmentosa by Unna and others.

Treatment and Course.—Treatment was begun on April 19, 1922, with the roentgen ray alone. Each treatment consisted of one quarter skin units, unfiltered. From that date until June 17, 1922, only the face, neck and hands were treated. During this period he received a total of one and one-half skin units, the intervals between treatments being somewhat irregular. Nevertheless, the lesions had definitely faded in color, and some had disappeared. The trunk and arms were then treated in the same manner with an occasional exposure of the face and hands. The patient was never regular in his attendance, but despite this, the response to roentgen-ray treatment was pronounced. Roentgen-ray exposures were finally stopped on Jan. 19, 1923, a total dosage of two and one-quarter units to the face, neck, and hands, and two and three-quarter units to the trunk and arms having been administered. To check the effect of the roentgen ray, no treatment was given to a cluster of lesions on the thigh and left ankle, and they have remained in essentially the same condition as when first seen.

For three months during the roentgen-ray treatment the patient took 8 grains (0.5 gm.) of whole suprarenal gland daily. Judging by the lesions that were not subjected to radiotherapy, this had no effect.

When treatment was discontinued, the lesions had practically vanished; some cafe au lait stains alone remaining (Fig. 2). These gradually disappeared, and for a number of months the treated surfaces were entirely free from all evidence of the disease.

In November, 1923, the patient noticed a new lesion on the dorsum of the right hand, and soon afterwards three lesions appeared below the right axilla. These lesions and several new ones on each cheek were evidences of a gradual but apparently progressive return of the disease. The returning lesions appeared to be new ones; a comparison of the photographs demonstrates that the present lesions do not occupy the position of former ones. The new spots present factitious dermographia (Fig. 3).

The patient's general condition has not changed during the course of the skin disease.

COMMENT

The results obtained in this case and in those recorded in the literature show that roentgenotherapy will cause involution of the

lesions of the adult type of urticaria pigmentosa. In three out of four recorded cases, including the present one, this result was obtained. However, in the case reported herein, the effect was not permanent: after a year of freedom from the disease, new lesions are appearing in the areas previously subjected to the roentgen ray.

THE TREATMENT OF PSORIASIS WITH INTRAVENOUS INJECTIONS OF SODIUM SALICYLATE *

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NEW YORK

As in every disease of unknown cause, there are many different methods of treatment for psoriasis. Most of these consist of local applications of ointments which, if not exceedingly irritating to the skin and destructive of fabrics with which they come into contact, are at least unpleasant because of the constant presence of greasy material on the skin and clothes. Any method of treatment, therefore, that does away with these unpleasant features would, if successful, be hailed with delight by the unhappy victim of this persistent affection.

Favorable reports by several dermatologists on the use of sodium salicylate intravenously seemed to point to a method of treatment that might be of decided benefit in many cases of the disease.

Sodium salicylate and especially salicin, administered by mouth, has been strongly recommended by Crocker and others. Some good results have been claimed for its use, both in cases with and without arthritic tendencies; but, in general, experience with its use has been disappointing, and it is uncertain whether it acts in any other way on the disease than as a depressant.

Sachs,[1] in 1921, reported on the use of intravenous injections of a 20 per cent. solution of sodium salicylate in thirty-four patients with psoriasis whom he had treated since 1918. His method of treatment was as follows: Injections were given every two or three days, beginning with 2 gm. and increasing 1 gm. each treatment until the dose of 4 gm. was reached. This dose was continued until from 21 to 28 gm. in all had been given. The injections were well borne, and the patients seldom complained of unpleasant effects. There was greatest benefit in recent cases. Inveterate psoriasis was hard to control, and recurrences had been noted. Sachs found this method especially applicable in cases in which extensive external treatment was contraindicated.

Bravo[2] in a short article in the *British Journal of Dermatology*, describes the treatment during some months by himself in conjunction with Dr. Sainz de Aja, at the Hospital de San Juan de Dios at Madrid,

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1. Sachs, Otto: Wien. klin. Wchnschr. **34**:185, 1921; abst. Arch. Dermat. & Syph. **4**:396 (Sept.) 1921.

2. Bravo, Julio: Brit. **34**:353, 1922.

in several cases of psoriasis by the intravenous injections of a sterile solution of sodium salicylate. They had usually employed a 20 per cent. solution but had also tried a 50 per cent. solution, which they discontinued because the patients felt a sensation of burning along the vein during the injection, and there was a marked tendency to thrombosis. They were accustomed to use 0.5 gm. as an initial dose, increasing 0.5 gm. at each dose until the amount of 3 to 4 gm. was reached. The interval between treatments was two or three days, and the maximum dose was repeated at these intervals for a length of time not stated.

They found that the patients tolerated this treatment exceedingly well; that acute cases were most amenable; but that they also obtained good results in inveterate cases and even in mixed conditions, such as psoriasis on a seborrheic base. They believed the good effects produced by the sodium salicylate to be due to the keratolytic property of the salicylic radical. Because of this belief, they decided to try this method of treatment on other keratotic conditions, and claimed to have obtained encouraging results in the treatment of keratoderma and hyperkeratosis.

Some of the patients who had received treatment for psoriasis were shown at meetings of the Society of Dermatology and Syphilology of Madrid. At the meeting of Oct. 14, 1921, Drs. Aja and Bravo [3] cited a case of psoriasis combined with rheumatism in which the patient was successfully treated with sodium salicylate. They also presented a patient with psoriasis who had been almost cured after a few intravenous injections.

In the discussion that followed, Dr. Aja stated that he thought that the fact that cases of psoriasis had been reported as cured by mercurial oil, mercuric cyanid, milk, etc., and now by sodium salicylate, suggested that these preparations do not act specifically but, by producing an internal shock, lead to a reaction to the organism which excites the natural defences that determine the cure.

At the meeting of the same Society on Nov. 18, 1921, Dr. Bravo [4] again presented the two patients seen at the session a month before. Both had been completely cured by intravenous injection of sodium salicylate, having received as a maximum dose 3 gm. every other day, with no other treatment, either general or local.

Lutembacher [5] reported a case of rebellious generalized psoriasis, in which sodium salicylate was injected intravenously daily in doses of 3 gm. dissolved in 80 c.c. of distilled water. On the eighth day of treat-

3. Aja and Bravo: Psoriasis, Arch. Dermat. & Syph. **5**:383 (March) 1922.

4. Bravo, Julio: Psoriasis Treated by Sodium Salicylate, Arch. Dermat. & Syph. **5**:521 (April) 1922.

5. Lutembacher, R.: Ann. de dermat. et syph. **6**:364, 1922; abst. Arch. Dermat. & Syph. **6**:631 (Nov.) 1922.

ment, the first improvement was noted, and after five weeks the entire eruption had disappeared.

AUTHOR'S CASES

In view of the encouraging results obtained in these cases, this method of treatment seemed worthy of a trial. Twenty patients with psoriasis attending the dermatological clinic at the New York University and Bellevue Hospital Medical School were used in this test. These patients presented most of the different types of psoriasis and had had the disease for periods varying from one to fifteen years, with an average duration of six years. There were nine males and eleven females, the ages ranging from 15 to 47 years, the average being 20 years. None had what might be called recent cases, but practically all gave the usual history of attacks followed by periods of freedom, either spontaneously or as the result of treatment. Many of these had been under treatment at this clinic from time to time for long periods and had received about all the accepted methods of treatment, with the usual results or lack of results.

The patients were all given the same preparation of sodium salicylate —a 20 per cent sterile solution put up in sealed ampules. Intravenous injections were given twice a week, starting with an initial dose of 0.5 gm., increasing 0.5 gm. at each subsequent injection until the dose of 3 gm. was reached. This maximum dose was continued during the remainder of the treatment.

The injections were usually well borne and no discomfort other than a generalized sensation of heat was felt, with the exception that three different persons complained at times of a sensation of burning along the course of the vein. One, a man aged 22, experienced this sensation at every injection after the fourth, the burning at times being so intense that it caused him to squirm and cry out, and it was only with great difficulty that he was able to remain on the table and submit to the completion of the injection. In no case did thrombosis result.

The number of injections varied in each case from five to twenty, with an average of nine, and the amount of sodium salicylate injected was from 8 gm. to 43.5 gm., with an average of 15 gm.

It was noted that there was an improvement in all patients receiving from seven to nine injections, as there was a decided tendency for the scales to disappear; in a few cases, this was so noticeable that the patients reported that "the spots dropped off." This disappearance of scales was most often seen in lesions covering a considerable area, with little infiltration, and particularly in lesions on exposed surfaces. (These patients, however, were being treated during the late spring and summer, at a time when there is apt to be an improvement in most cases, and exposure to the sun may have played and probably did play a considerable part in the result obtained.)

Lesions on the covered surfaces, guttate and small nummular lesions with more or less infiltration did not react so well. There was no lasting improvement in any case, as all lesions recurred within a short time after cessation of treatment. No patient was cured.

During the administration of the sodium salicylate intravenously, no other treatment, either general or local, was given, except in a few instances when patients practically demanded some salve, and then plain petrolatum was used as a placebo.

It is probable that whatever effect was obtained was due to the keratolytic action of the salicylic radical in the solution, and this effect could probably be just as readily obtained from the external application of salicylic acid itself.

While the number of cases in which this method of treatment was used was not very large and, as is usual with clinic patients, it was impossible to get all of them to attend regularly and to continue treatment as long as desired, yet I think that enough injections were given to several patients to demonstrate the efficacy or lack of efficacy of this method of treatment.

From my experience in the use of sodium salicylate intravenously, I decided that the meager beneficial results obtained did not warrant the continuance of its use, and it was therefore discontinued.

SUMMARY

1. Intravenous injections of sodium salicylate have been strongly recommended in the treatment of psoriasis, and several cures have been reported.

2. A trial of this method in twenty cases proved disappointing, only slight benefit being derived and no cures obtained.

3. The use of salicylic acid externally would probably be just as efficient as sodium salicylate intravenously.

Abstracts from Current Literature

Clinical Aspects of Cutaneous Reactions After Arsphenamin. J. V. Klauder, J. A. M. A. **82**:933 (March 22) 1924.

These manifestations are divided by the author into two groups: (1) erythematosquamous eruptions, and (2) nitritoid reactions. The first group comprises cutaneous pictures ranging from erythema to dermatitis exfoliativa; while the second group comprises nitritoid crises and urticaria. Besides these objective manifestations, subjective reactions (pruritus and paresthesia) are discussed. These subjective symptoms are definite indicators of intolerance, and are warning signals against the further use of arsphenamin.

The article is accompanied by a number of excellent photographs.

Solitary Tuberculous Ulcer of Lip. G. T. MacPherson and H. W. Gregg, J. A. M. A. **82**:966 (March 22) 1924.

This is the report of a case in which the diagnosis was in doubt until a biopsy was made. The patient had active pulmonary tuberculosis, with tubercle bacilli in the sputum.

Michael, Houston, Texas

The Endocrine Sympathetic Syndrome of Alopecia Areata. A. Levy-Franckel and E. Juster, Press méd. **30**:855 (Oct. 4) 1923.

In 1886, Max Joseph, and in 1887, Mibelli, sectioned the posterior branch of the second cervical nerve, producing in the innervated area of this nerve, alopecia resembling alopecia areata of man. On these experiments, the authors base their contentions that alopecia areata is due to sideration of the piliary fibers of the sympathetic nervous system, which is under the control of the endocrine system. They discard completely the micro-organism theory of alopecia areata. In most of their cases of alopecia areata, they have found both vasomotor and endocrine disturbances. They have obtained good results from opotherapy, as well as direct radiation of the thyroid gland.

Second Congress of Dermatology and Venereology of the French Language (Strassbourg, July 25, 26 and 27, 1923). Presse méd. **31**:710 (Aug. 15) 1923.

Sensitization and Desensitization in Cutaneous Affections.—Ravaut stated that the sensitized person is the one in whom the organism has acquired, under the repeated influence of an antigen, the property of reacting constantly to doses which he well supports at other times and which, under the same conditions, permits the normal person to be insensitive. In a second chapter are given the principal methods of desensitization. Their purpose is, by different methods, to neutralize these newly acquired properties of our body fluids, and to bring the organism back to its normal state. In a third chapter he groups the different facts of cutaneous conditions which enter into the picture (urticaria, Quincke's disease, pruritus, prurigo, strophulus, eczemas, artificial dermatitides, recurring bullous disease, Duhring's disease, recurring herpes, recurring erysipelas, furunculosis), and insists on the therapeutic methods which are applicable

to them. He believes that this is a new chapter in dermatology which should be thoroughly studied, as one may frequently obtain good results when all other treatment fails.

Spillman (of Nancy) said, after he had defined the state of sensitivity and the phenomena of desensitization, that it is indispensable, in order to employ usefully the desensitizing method in dermatology, to be able to judge the sensitivity of an organism and to know the diseases of the skin in which one may invoke the intervention of a sensitizing substance. All substances which cure are not desensitizers. It is necessary to distinguish between the states—anaphylactic sensitization and hypersensitivity—which appear to confound themselves in a state of permanent colloidal instability. The author believes that sensitization appears in the origin of certain dermatoses: urticaria, eczemas, artificial dermatitides, diffuse erythemas, edema, pruritis, prurigo, etc. The second chapter comprises a list of known sensitizing substances: animal and vegetable albumins, medicines, diverse substances, etc. Among the methods of susceptible desensitizers to be employed in dermatologic therapy, the author studied the specific desensitization (progressive specific by intravenous or subcutaneous injections, by ingestion, by cutaneous reactions, by effectual cutaneous applications by means of an antigen); the nonspecific desensitization (protein therapy, by chrystaloids, by brutal shock); the therapeutic methods recalled by the desensitizing methods (autohemotherapy and autoserotherapy) and the therapeutic aids (modification of the vagosympathetic equilibrium, opotherapy, modification of the soil, the rôle of hepatic insufficiency and the insufficiency of the organs of elimination).

Brocq regretted that this extension of the domain of anaphylaxis appeared to him premature; it is not even established on a sufficiently studied scientific basis. The modifications of the blood which constitute the hemoclassic crisis have not been established with sufficient precision in a number of diseases. The colloidal classic diathesis rests only on newly demonstrated findings; it is only a simple hypothesis. The therapeutic argument is of minor value, since the same drug may act well in different conditions. He believes that one should speak of this subject only with the greatest reserve.

Milian believes that the question is poorly stated. The anaphylaxis of Richet is a precise fact, but its mechanism remains unexplained. The colloidal classic, on the contrary, is a theoretical fact not demonstrated. He shows that one speaks of the nitritoid crisis of arsphenamin which supposedly is caused by the precipitation of the molecules obliterating the capillaries. How, then, can one explain the action of epinephrin which is a vasoconstrictor, which should add to the difficulties of circulation when given in this condition, but which clears up the nitritoid process?

Hudelo has for a year treated various conditions systematically: With autohemotherapy, he obtained no result in eczema, except in one case; he had some success in pruritis, particularly in anopruritis, urticaria and chronic furunculosis. With autoserotherapy, the results were analogous, but more favorable, and there were more lasting modifications in eczema and occupational dermatoses. The author does not think that the therapeutic results are regular in their action.

José and Peyri (of Barcelona) obtained good results, in certain dermatoses, with injections of milk into the lumbar region.

Nicolas, Gaté, Dupasquier, Lebeuf and Dumollard (of Lyon), continuing their researches on hemotherapy in furunculosis, came to the conclusion that good results were shown, not only with autohemotherapy but also with homo-

hemotherapy (injection of the blood of a human being infected with furunculosis) and with heterohemotherapy (injection of the blood of the rabbit and of the guinea-pig).

Lortat-Jacob and Legrain showed that modifications of basal metabolism permit one to detect the alterations of the thyroid gland and the exact influence of opotherapeutic treatment, the study of the respiratory changes revealing some most interesting facts on the subject of the etiology of some dermatoses and their treatment. Wihout being able to give a definite conclusion on their researches, the authors have found a diminished basal metabolism (hypothyroidism) in scleroderma, fortunately modified by treatment, and an increased basal metabolism (hyperthyroidism) in acne and seborrhea.

Dujardin (of Brussels) recalled that a special desensitization of the skin appears at the end of the third period of syphilis (allergy). One may mention here the so-called specifics (luetin, pallidin).

Conduct of the Treatment of Syphilis in the Prehumoral Period.—Queyrat stated that there are two phases of primary syphilis: first, the phase in which the chancre is auto-inoculable and the Wassermann test negative, and second, the phase in which the chancre is no longer auto-inoculable and the Wassermann reaction is positive. The positive Wassermann reaction apparently does not begin at the moment that the auto-inoculability terminates (twelfth day), but usually some days later (from one to eight days), that is, from the thirteenth to the twentieth day after the appearance of the chancre. The period during which the chancre evolves before the Wassermann test is positive may be called the "prehumoral period." In this period, the chance for complete sterilization is greatest, especially, the first ten days. The most active medicaments against the spirochetes are: first, arsenic, arsphenamin, neo-arsphenamin and sulpharsphenamin; second, bismuth preparations. Mercury seems to have little influence on the serum reaction. With regard to the arsenical preparations, the most efficacious method is the intravenous. After having tested the sensitivity with feeble doses, it is advisable immediately to employ large doses in rapid progression. Large doses are well supported in the prehumoral period. This treatment should continue for one year. If the blood is negative at this time and has remained so the second year, the patient should be merely serologically controlled. At the end of the second year, a blood test and a spinal puncture should be made. If everything is normal, the patient may be considered cured. A cure is the rule in syphilitic patients properly treated in the prehumoral period, especially when the treatment is begun during the first ten days after the appearance of the chancre. This is based on an entirely negative serologic and clinical examination, absence of marital contagion, healthy children and a number of cases of authentic reinfection over a period of five, seven, nine and ten years. Intramuscular treatment with neo-arsphenamin, sulpharsphenamin and bismuth may be equally good, but the chances of cure with the intravenous injections way are probably better.

Malvoz and Halkin (of Liége) believe that mercury should be given with arsphenamin during the first course. The percentage of cures according to the French writers is about 75; foreign statistics raise it to 90.

Oltramare (of Geneva) believes that the best results are obtained when treatment is begun before thirty days, after which time the infection becomes generalized. He recommends small doses of arsenic in the beginning in order to overcome the arsenical resistance.

Hudelo divided the prehumoral period into two periods: the mediocre period, which ranges between the tenth and seventeenth day after the beginning of

the chancre, and an excellent period, which is between the first and the tenth day. He emphasizes the importance of making the diagnosis in the latter period.

Lévy Bing said that he tried to discover the date of contamination. The Wassermann test becomes positive from thirty-eight to forty-two days after this date.

Jeanselme stated that most syphilologists are in agreement with reference to the division of the primary stage into two periods: the first, preserological is, correctly speaking, the primary period; the other should be attached rather to the secondary period, just preceding roseola. The author believes that the serologic reaction is the most important, for one cannot accept the statement of coitus made by patients. He prefers arsphenamin or neo-arsphenamin given intravenously. He made weekly serologic curves in patients with secondary syphilis, comparing the results of arsphenamin, neo-arsphenamin, bismuth and calomel. He arrived at the conclusion that of all the drugs, the one that has the most rapid reaction on the Wassermann test is arsphenamin, then neo-arsphenamin, then bismuth and finally mercury. After arsenical and mercurial treatment it is wise, even in the absence of all clinical and serologic signs, to repeat the arsenomercurial course twice, and in the event of a negative lumbar puncture, the patient may be called cured. One is aware that in the secondary period many of the meningeal reactions are only a short blaze and disappear some time spontaneously, but if these same meningeal reactions are observed a year after the beginning of the chancre, they are indicative of syphilis of the nervous system, which it is necessary to treat actively.

Goubeau pointed out the febrile reaction which is produced only in the prehumoral period, indicating that already the patient has a generalized syphilis and should be treated most vigorously.

Carle (of Lyon) insisted on the continuation of treatment for two years at least, in all conditions except during the prehumoral period. He favors arsenic-mercurial or arsenic-bismuth treatment.

Indré Léri, Tzanck and Véron have studied the serologic reactions in a series of thirty-eight cases of chancres treated during the prehumoral period: seventeen were treated by arsenic, nineteen by bismuth. The results of comparison are, with bismuth as with arsenic: All the chancres treated before the twelfth day have eventually a negative Wassermann reaction, but with the one as with the other, the reaction may become momentarily positive (crochet positive) in the course of treatment. In the chancres treated very early, bismuth has prevented a momentary positive reaction at least, as well as arsenic. It seems that a small dose of bismuth is sufficient in order to arrive at this result, when a small dose of arsenic remains insufficient. In chancres treated later in the course of the third week, the arsenic seems to be able to keep it continually negative, whereas bismuth produces occasionally a momentary positive. On the other hand, when the reaction becomes positive with arsenic, it remains definitely positive, whereas a positive reaction with bismuth is often momentarily so. These results seem a little paradoxical at first, but if one considers that the salts of arsenic are soluble products, whereas the salts of bismuth are insoluble products, bismuth is absorbed more slowly, and its action is more contiuous, progressive and lasting. In conclusion, bismuth treatment in the prehumoral period appears to be put nearly on the same footing as arsenic.

Early and Abortive Treatment of Syphilis. Control of Results Six Months Later.—Paul Meynet (of Nice) reports the observation of the brothers who, at fifteen days' interval, were exposed to the same woman, who had a virulent

secondary syphilis. The first one contracted syphilis and was rapidly sterilized by intensive treatment which commenced four days after the appearance of the chancre; there were no early or late lesions. The Wassermann test remained negative. The second brother by reason of circumstances, submitted to an abortive treatment twelve days after coitus. No lesion appeared, and the serologic reaction was always negative.

Halbron, Barthélemy and Isaac Georges stated that arsenical treatment in the dispensary should be regular, intensive and prolonged, or not at all. Mercurial treatment in the dispensary is only given from the point of view of prophylaxis. Bismuth is the most favorable ambulatory treatment because of its efficacy, its relative harmlessness and its ease of administration, which allows one to give it in dispensary visits. (*To be continued*).

TERTIARY SYPHILITIC MENINGITIS WITH FEVER AND CORRESPONDING TO PSEUDO-MALARIA, H. SCHAEFFER, Presse méd. **31**:772 (Sept. 8) 1923.

The author cites a case which came under his observation in the hospital. The patient had a characteristic pseudomalarial temperature curve and all the cardinal signs of meningitis. Physical examination was entirely negative, except for the foregoing findings. A lumbar puncture was performed three times. The last time the blood was examined for syphilis and proved to be four plus. The patient was given neo-arsphenamin intravenously. All the symptoms cleared up immediately. The temperature became normal. Fever in tertiary syphilis has been reported. In latent nervous syphilis, fever is exceptional. The interesting feature was a pseudomalarial type of temperature in a patient presenting meningitic symptoms.

McCAFFERTY, New York.

A CASE OF "CREEPING DISEASE" (LARVA MIGRANS) SEEN IN STUTTGART, SCHAUMBERGER and TANNHAUSER, Dermat. Wchnschr. **77**:1165 (Oct. 6) 1923.

Descending from the left scapula of a man, aged 21, were two fairly straight and nearly parallel erythematovesicular lines, clinically characteristic of the eruption of larva migrans. The organisms were not found, but were probably of animal origin, for the patient had visited a circus ground on the day preceding the appearance of the eruption. One point was frozen with ethyl chlorid in an attempt to find the organism, but there was no other application, and healing was apparently complete within fourteen days.

A SECOND CASE OF POROKERATOSIS OF MIBELLI. MENAHEM HODARA, Dermat. Wchnschr. **77**:1167 (Oct. 6) 1923.

A photograph shows the scroll-shaped lesions on the cheek of a man, aged 52, who had had the condition for twenty years, the dorsum of one hand and one shoulder also being involved.

HISTOLOGIC INVESTIGATION OF A CASE OF POROKERATOSIS OF MIBELLI. M. HODARA and H. BEHDJET, Dermat. Wchnschr. **77**:1168 (Oct. 6) 1923.

A man, aged 35, had had the affection for fourteen years, and presented early and late lesions on the upper and lower extremities, which are shown in illustrations. A detailed histologic report is given, the findings being characteristic of the disease.

THE ACTION IN MAN OF THE ENDOTOXINS AND ECTOTOXINS OF THE TRICHOPHYTONS, AND THEIR THERAPEUTIC VALUE. W. ENGELHARDT, Dermat. Wchnschr. **77:** 1193 (Oct. 13) 1923.

From observations in sixteen cases the author concludes that injections of the endotoxin are the more toxic, call forth reactions of greater duration, often accompanied by fever and possess a greater specificity. Both the endotoxin and the ectotoxin are thermolabile. Therapeutically, in conjunction with local treatment, the former is the more valuable, but in the opinion of the author the best results may be obtained by the use of a mixture of the two in which the ectotoxin predominates.

THE VALUE OF OLD CULTURES OF PATHOGENIC YEASTS. GINJI KOOMAYA and ERNST ROSENBAUM, Dermat. Wchnschr. **77:**1198 (Oct. 13) 1923.

Dried cultures twenty years old could be cultivated and transmitted to animals.

STAINING EXPERIMENTS AND THEIR MODIFICATIONS IN THE PRECIPITATION REACTIONS FOR THE DIAGNOSIS OF SYPHILIS. H. MIERZECKI, Dermat. Wchnschr. **77:**1202 (Oct. 13) 1923.

Designed with a view to hastening and facilitating the procedures, the technic is described as applied to the reactions of Sachs-Georgi, Dold and Meinicke.

A NEW SEROLOGIC METHOD FOR THE DIAGNOSIS OF LEPRA. H. MUCHOW and D. M. LEVY, Dermat. Wchnschr. **77:**1225 (Oct. 20) 1923.

The authors have devised a precipitation reaction which is apparently specific for lepra. The serum of the patient is used for the test, the antigen being an extract from leprous nodules. The technic is described.

BISMUTH THERAPY. EVENING, Dermat. Wchnschr. **77:**1234 (Oct. 20) 1923.

In the author's experience, the bismuth preparations seem therapeutically superior to the mercurial, although distinctly inferior to the arsphenamins. They may be expected to replace the mercurial drugs for treatment in combination with the arsenicals, and they may be substituted for the latter in cases where arsenic is not tolerated. Bismuth and mercury should not be used together because of the uncontrollable mass action after intramuscular injection, and because of the danger of stomatitis.

THE DIAGNOSTIC SIGNIFICANCE OF EPIDERMAL INOCULATIONS WITH DILUTED TUBERCULIN SOLUTIONS OF GRADUATED STRENGTH. KOOPMANN, Dermat. Wchnschr. **77:**1253 (Oct. 27) 1923.

Using old tuberculin by the Ponndorf method in a series of 253 cases, the author found that in the more severe cases the onset of the skin reaction occurred earlier after inoculation, and that a severe reaction usually indicated that the patient was resisting the infection. He found a specific and a nonspecific element in each reaction of the skin, and the occasional systemic reactions appeared to be of less value. An advantage of this method is that the general reaction is usually mild, and the author concludes that this system of successive inoculations is of value in diagnosis and prognosis.

Reticular Skin Changes, Especialy Those of Inflammatory Nature (Cutis Marmorata Pigmentosa of Buschke-Eichhorn). A. Buschke, Dermat. Wchnschr. **77**:1266 (Oct. 27) 1923.

Referring to the recent publication of Lehner and Kenedy in the *Wochenschrift*, Buschke reviews his work on the subject, including the division of cutis marmorata into three types: vasculosa, pigmentosa and hyperplastica. He stresses the difficulties encountered in the study of the pathogenesis of the condition.

A Case of Bilateral and Symmetrical Zoster of the Upper Extremities and Loins. Hans Krösl, Dermat. Wchnschr. **77**:1267 (Oct. 27) 1923.

Both sides of the upper and lower parts of the back were involved, and also the extensor surfaces of both forearms just below the elbow. The patient was a boy, aged 17.

The Treatment of Oriental Boil. P. Vaiciuska, Dermat. Wchnschr. **77**:1285 (Nov. 3) 1923.

The author reviews various methods of treatment and recommends currettage followed by the application of silver nitrate or liquor ferri sesquichlorati. Using the latter, which he prefers because it is milder, at intervals of three weeks or a little less, three applications has been the maximum required to effect a cure.

Histologic Examination of the Bullous and Atrophic Parts of a Case of Epidermolysis Bullosa (Koebner). M. Hodara and H. Behdjet, Dermat. Wchnschr. **77**:1288 (Nov. 3) 1923.

A man, aged 21, had had the affection since birth. Histologic study of the bullae showed that the papillary blood vessels were dilated and that the papillae were extremely edematous, intercellular and intracellular edema extending into the epidermis, with changes in the prickle cells. In the atrophic skin, the epidermis was very thin, papillae were lacking, and no elastic tissue could be found.

The Elimination of Bismuth in the Urine After Parenteral Injections of Sodium Tribismuth Tartrate. S. Sei, Dermat. Wchnschr. **77**:1290 (Nov. 3) 1923.

In a study of the urine of four patients, three of whom had been treated intramuscularly and one intravenously, from 0.085 to 0.64 mg. of bismuth could regularly be recovered from 500 c.c. of urine, and the elimination of the bismuth continued for a long period of time.

Indications for Roentgen-Ray Treatment in Various Forms of Eczema. Herbert Fuhs, Dermat. Wchnschr. **77**:1313 (Nov. 10) 1923.

Using a hard ray and from 0.5 to 1 mm. of aluminum as a filter, the author administered doses of from one-half to three Holzknecht units each in series of four to six treatments from two to four weeks apart. Excellent results were thus obtained in the ordinarily resistant recurrent eczemas of infants and adults. Eczema of the leg with a varicose basis did not respond well to this treatment, nor did the fissured eczemas of the palms and soles. By prompt adherence to the technic, untoward results were avoided.

Parkhurst, Toledo, Ohio.

Society Transactions

NEW ENGLAND DERMATOLOGICAL SOCIETY

Quarterly Meeting, Dec. 12, 1923

HENRY J. PERRY, M.D., *President*

LICHEN OBTUSUS CORNEUS. Presented by DR. BRAGG.

A woman, aged 36, a domestic, had a negative and personal family history. Her general health had been very good. Sixteen years before presentation she had noticed a few papules or vesicles on the forearms. The number had gradually increased, now extending over most of the extensor surface of the upper arm and forearm (most of them appearing as papules). About nine or ten years ago the eruption appeared on the lower extremities, and it now involves the entire surface of the legs and the outer aspect of the thighs and buttocks. There are some lesions across the shoulders, and in recent weeks some have appeared on the face. These lesions are entirely free from pain, but are extremely uncomfortable on account of the intense itching day and night. This symptom has been constant from the very first. The progress has been gradual and steady. There are two or three things to be especially noted. Many of the lesions have been capped with small vesicles; and there are some large nodules on the dorsal surface of the lower part of each leg.

DISCUSSION

DR. TOWLE discussed the case in some detail, calling attention to the lichenoid character of the lesions, the continuous and marked itching, the nervousness, and emphasized the fact that the scratching undoubtedly had a great deal to do with the appearance of the lesions.

DR. LANE said that it was an unusual case in that it was a real case of prurigo nodularis or lichen obtusus corneus. He had run across a picture in Stelwagon's book which was almost a duplicate of this. The unusual feature was the vesiculation, which appeared at the very start instead of later. He thought the nodules, the appearance of the lesions, the infiltration and itching all fitted in with the picture.

DR. BURNS agreed with everything Dr. Lane said in regard to prurigo nodularis or lichen obtusus corneus. He was also inclined to agree with his contention that one sees various degrees of vesiculation in connection with that disease, and that it is not infrequent. In the several cases of prurigo nodularis which Dr. Burns had seen, there had been well defined minor vesicles in large areas of lichenification. He thought the few cicatrices on the extensor surface of the arms, particularly, might be accepted as secondary consequences of the disease and the severity of the pruritus, because it sometimes happened that such lesions became so traumatized that they were converted into sluggish ulcerations which continued for some time, and in the course of healing left scars. He considered first and last that all the symptoms and the history as

well were entirely consistent with a case of prurigo nodularis as conceived clinically. What the patient had in the background he thought was another story.

Dr. Oliver said that there was an almost exactly similar case in the hospital a few years ago, with itching which caused scratching and scaling. As to treatment, in that case some of the lesions were removed by excision and they reappeared quite promptly in the suture, in the scars.

Dr. Cummins said he thought it was remarkable that there had been so little scarring in this case which had been of sixteen years' duration, with intense itching, almost constantly, day and night.

Dr. Bragg said, in response to a question about treatment, that he had tried all the local applications he had reason to believe would give any relief, and so far as he could determine they were without any beneficial effect. No combination had relieved the itching, and the only benefit obtained had been from unscreened roentgen-ray treatment. Last spring, after about ten treatments, there had been nearly complete relief from the itching for a period of several weeks. During the summer vacation, however, the itching returned, and this fall five or six treatments apparently had been without effect. Dr. Bragg thanked the Society for approving the diagnosis, but desired some suggestion as to treatment.

Dr. Blaisdell said he had seen a case some time previously somewhat similar to this one except that the distribution was confined to the nodules, and there was no infiltration on the legs. In desperation he had her use a fairly strong solution of salicylic acid, which she applied to the nodules themselves, with great relief for a period of three months. She then went out West, and he had not heard from her since. The salicylic acid, for the time being at least, had given her more relief than anything else she had tried, and she had had roentgen-ray treatment, radium and chrysarobin. It peeled off the elevations so that she did not strike them with her nails if she rubbed her arms or legs, and it worked very well.

Dr. Jacoby said that during the past year at a clinic at the Homeopathic Hospital there had been a case of prurigo in a child, which was very interesting. It was found that prescribing thyroid in small doses would entirely control the itching, and several tests of taking away the thyroid were made, with the result that the itching would immediately start up again. As long as the youngster was taking thyroid the itching was entirely controlled. This might be a suggestion in the present case.

Dr. Burns said that he could recall four cases of prurigo he had had under his care, none of which he had succeeded in curing, although he thought he had succeeded in ameliorating the condition and making the patients more or less comfortable. He thought the roentgen ray did not influence the nodular thickening, which is a pure lichenification. For that condition, it seemed to him that the use of 10 per cent. potassium hydroxid used carefully over the lesions had more effect in reducing them than anything else he had tried, including salicylic acid. For any of the intervening lichenifications in any degree such as the present patient showed, and for the control of the pruritus in general, it seemed to him that the roentgen ray was the best treatment. At least it gave the patient more relief and tended to control the pruritus.

GRANULOMA FUNGOIDES. Presented by DR. BOARDMAN.

A man, aged 61, a bookkeeper, had had the present trouble for one year. It began with tumors or bunches under the knees, and scaling. The bunches came first and the scaling later. At present, the patient has scaling all over and hard nodular bunches under the knees and in the groins; also a general eruption which itches intensely, interfering with his work. He has received considerable local treatment. There are rather large tumors, which might be glands or something else. These nodules are pretty well marked behind the knees. One fairly large one has recurred.

DISCUSSION

DR. TOWLE said that he was very much interested in this case. He wondered whether it was one of those cases of universal thickening of the skin which later becomes associated with blood changes, bringing it into the group of leukemias, and that goes through leukemia cutis, Hodgkin's disease and granuloma fungoides. The lesion on the scrotum resembled it, and those on the legs might be developing into it. The story of the blood in all universal thickening of the skin is interesting. He said that they had a woman at the Massachusetts General Hospital who had a skin like that of this patient—red and rough to the touch—and at first, in spite of nodules developing on all parts of the body, her blood picture was normal. Then the condition went through the changes suggesting leukemia. About the time the blood began to change the nodules began to break down, and the last diagnosis was mycosis fungoides. Prior to that she had tremendous overgrowths. The story of the primary lesion in the skin, preceding a blood change, was very interesting. It brought to mind other cases of that group, about which Dr. Swartz would remember there was much discussion. At first the blood clinic was inclined to maintain that the primary change was in the blood. Later they changed their opinion and decided that the primary change was in the skin. The present case reminded him of some of those cases.

DR. OLIVER agreed with Dr. Towle. He thought probably the case belonged to that group. The lesion on the scrotum was there, and the redness of the skin was compatible with mycosis and the ordinary stages of leukemia of the skin. It seemed to him that they belong in one group, as pathologists do not seem to be able to separate them.

DR. BOARDMAN remarked that it was interesting in this case that the first lesions the patient noticed were the ones behind the knees—the nodules. He never had had any itching. After the general skin eruption occurs usually gets this premycotic stage and then the tumor. He said he realized that showing a case without having any picture of the blood was not the proper way, but it was rather an interesting case for observation. Possibly it could be showed later when there was a more complete diagnosis.

DR. BLAISDELL asked whether one would ordinarily expect the premycotic stage to appear on the knees or on the scrotum rather than on the trunk. He thought the course was rapid since the condition had started in December and there were such large tumors in June.

DR. TOWLE recalled a case similar to this, that of a man who developed lesions with tremendous rapidity. Not only did they ulcerate, but those lesions burrowed. They finally got down into the muscles, burrowed all the way down, and at necropsy it was found that he was just a mass of pus.

Dr. Blaisdell mentioned a man in the ward who was burned by falling into a vat of nephthalene and who developed a premycotic stage. He then developed leukemia and died.

Dr. Oliver said that the first case of mycosis he ever saw had no premycotic stage at all. The patient just had one large tumor in the lower part of the abdomen. Others developed rapidly, and in two or three months he was covered with them. The original lesion in the beginning was supposed by Dr. Post to be a primary lesion of syphilis.

Dermatitis Factitia (?). Presented by Dr. Boardman.

A girl, aged 16, had had lesions intermittently for a year and a half. Her whole arm was hyperesthetic and tender, but there was a touch of anesthesia. The crusts on the lesions had disappeared, but when she went home a few days ago practically all the lesions had a black crust over them. On one lesion there was a curious imprint, somewhat resembling a coin.

DISCUSSION

Dr. Blaisdell mentioned a girl who was a patient in the neurologic service. Her case was considered one of hysteria. The condition of the skin was one manifestation of it. She also had other signs, but they never found one of those spots without finding little side pieces as if some fluid had run down from it. It suggested the pressing of a coin, but they admitted that they never had seen a coin that would give that particular imprint. In reply, Dr. Myerson said that the skin of some neurotic persons does not act like that of normal persons. A different kind of lesion is produced. Dr. Blaisdell said he considered the whole picture one of hysteria, and it seemed to him that phenol would account for the black spot.

Dr. Towle said that these cases try one's soul both as to proving the diagnosis and as to curing the condition. Neurologists ten years ago would not admit as a rule that there were such things as self-inflicted injuries of this type. He thought they had been convinced.

Dr. Fitzgerald said that some years ago in a school with which she was connected it was not unusual to see these cases; the girls would put needles and pins in their legs; she thought it not improbable that girls would use phenol. She said that occasionally one would find girls who would do those things so that they would not have to work or go in the kitchen. For treatment, the girls' hands were usually tied behind their backs and the girls were kept in their rooms; they always recovered. Dr. Fitzgerald said she did not think it a good plan to have these cases shown up in this clinic, as the girl in question came in and enjoyed it.

Dr. Towle remarked that the patient mentioned to him that the lesions did not get well until they were removed by excision, and that it was not an unnatural obsession. He remembered a stout, healthy looking teacher from upper Vermont who had lesions on her arms and then on her trunk. She was convinced that they would never get well until they were cut out, and her one obsession was to go to some hospital and have them cut out.

Dr. Blaisdell remarked that three years ago the hospital had a case in which the motive was different. Compensation was being sought for a girl who was burned. She had those sore spots. They persisted for more than a year, and they were so bad that the secretions from her skin burned holes

through the dressings. The thing which brought the family physician to the hospital was that the secretions burned through a heavy overcoat. The patient brought the overcoat in and showed the hole. She was taken into the ward. The border around the cloth was analyzed, and it was found that the sores were being caused by an application of 25 per cent. caustic soda. It was never ascertained whether the mother was doing it or the girl, but when they were threatened with jail this trouble ceased. They slipped up on one thing. They applied the caustic soda to the outside of the cloth and the outside of the cloth was burned, whereas the secretion coming out would burn the other way. Dr. Blaisdell said he spent an hour reading the record of the case. There was serious contention as to whether the patient was entitled to compensation. He did not think one could tell from the crusts in the present case whether the cause was phenol or an alkali.

LUPUS VULGARIS (?). Presented by DR. BOARDMAN.

A girl, aged 12, for about two months had been having spots appear on her face; one of them was becoming larger. Dr. Boardman said he thought it was quite an early case of lupus vulgaris, and stated that he did not see many in the outpatient department.

DISCUSSION

DR. OLIVER said he thought the condition seemed more like lupus erythematosus, and that the tonsils and teeth should be looked after carefully. An extensive case of lupus erythematosus, covering both cheeks entirely cleared up two or three months after the tonsils were removed and the teeth taken out. In the beginning the lesion had been frozen in two or three areas. This left scars which were unsightly, almost as unsightly as the lupus erythematosus.

DR. TOWLE said that there are cases of lupus erythematosus in which the differential diagnosis is sometimes exceedingly difficult. He had seen a number in which he was convinced at first that they were lupus erythematosus and which later would, he thought, develop lupus. He thought probably it was a lupus apple-jelly nodule. The case presented was probably lupus erythematosus, and he was much interested in the tale about the teeth.

DR. BOARDMAN reported a case of profuse lupus erythematosus. The patient had an appendix operation, following which the lesions cleared up wonderfully. In a week or two they were all back. She went to the Massachusetts General Hospital and after that he did not see her again. Probably she died. The symptoms changed a good deal while she was there. He thought this case was lupus vulgaris because the nodules were distinctly brown.

DR. TOWLE reported that at the last meeting of the American Dermatological Association, Dr. McLeod read a paper on lupus erythematosus, and he utterly tabooed or derided the tuberculous theory. He said in his paper that the condition was due to a toxin, not necessarily tuberculous. The cases cited would reinforce his remarks.

DR. BLAISDELL remarked that apparently in some cases there is a focus not necessarily bacterial. He remembered the case of a girl (and he thought children showed more activity perhaps than adults) of 12 or 13, who was very sensitive to mosquito bites. She lived near the woods and for several years had had lesions in the spring after the onset of mosquitoes. These lesions survived for several months, until cold weather.

Dr. Lane cited a recent hospital case. A little girl, aged 12, had lesions on her forearms that looked much like an acute erythema multiforme. He felt that she was perhaps one of the acute lupus erythematosus type. A further examination showed tubercle bacilli in the urine, and the roentgenogram of her chest was at least suggestive of tuberculosis. After a number of examinations, tubercle bacilli were found in the sputum. The condition was probably in the nature of a true tuberculid rather than lesions of the lupus erythematosus type.

Raynaud's Disease (?). Presented by Dr. Boardman.

A man, aged 21, Polish, a packing house employee, had symmetrical edema of the fingers and toes, with rather severe pain, of six days' duration. He has had a little fever. The pain had disappeared after cold applications. He still had purplish, cold toes, fingers and ears. The symmetry of the lesions and the location, together with the short duration indicated frostbite, but Raynaud's disease should be considered.

DISCUSSION

Dr. Lee asked whether this might not be a pernio, as he may have been exposed to cold brine, cold floors, etc. He thought at first it was Raynaud's disease, but he also thought of pernio.

Dr. Perry reported that the history had shown that the man had his hands in cold water, that there was some salt about, and that he was handling cold meats.

Dr. Towle called attention to the similarity with conditions in cold weather in Flanders in 1914, and discussed etiologic factors in the production of such conditions: continued exposure to cold, congestion, stasis, swelling and pain. He thought the condition was an aggravated pernio rather than Raynaud's disease.

Dr. Lane agreed that Dr. Towle's explanation was reasonable, and he felt that the diagnosis of pernio, with such a history, would class it as an industrial dermatosis.

Rupial Secondary Syphilid. Presented by Dr. Boardman.

A man, aged 26, was presented because of the rupial lesions present. He had a probable primary lesion in his throat, and practically all the lesions on his body were covered with a heavy, thick, rather typical rupial crust. With treatment, these had changed slightly so that there was a little scaling and the crusts were not as adherent as formerly.

DISCUSSION

Dr. Cheever agreed that the condition should be called an early precocious syphilid. He said that there had been some cases at the Massachusetts General Hospital of that general type in men who usually had been drinking heavily when they contracted syphilis. He recalled two patients—one a professional baseball player, the other a pugilist. Both had serious cases, and he wondered why they were in a poorer condition than they appeared to be.

Dr. Lane recalled seeing one case while he was in the army, that of a boy who had extensive rupial lesions early in the course of secondary syphilis. He had lost a tremendous amount of weight. He had been on a transport a

long time coming back to this country and was in extremely poor general condition. He thought, in that case, the poor general condition accounted for his rather severe type of lesion.

DR. BOARDMAN said that this was probably the explanation of these lesions, but it would not explain the itching. The boy had severe itching; it was not possible to argue him out of that fact.

NEW YORK DERMATOLOGICAL SOCIETY

Dec. 18, 1923

WALTER J. HIGHMAN, M.D., *President*

ACTINOMYCOSIS. Presented by DR. FRASER.

A man, aged 39, single, a silk packer, whose family and personal history was negative except that he had been subject to frequent attacks of toothache, on Nov. 16, 1923, had one of these attacks in a right lower molar, which was followed by the appearance of a reddish indurated mass over the midportion of the lower jaw. Dr. Ferris saw the patient on November 19, made an incision one-half inch in length over the margin of the jaw, evacuated a small quantity of pus, and curetted and packed the wound with iodoform gauze. Instead of improving after this procedure, the mass continued to grow larger. Dr. Ferris referred the patient to the Norwegian Hospital, and on December 9 curetted the whole of the diseased area.

Dr. Theodore Curphy, pathologist of the hospital, examined sections of the tissue microscopically and made a diagnosis of actinomycosis. The Wassermann reaction was negative and the blood count normal. Roentgen-ray examination revealed no osteomyelitis.

DISCUSSION

DR. FRASER agreed with Dr. Whitehouse and the others that it was a rare dermatologic condition, and that dermatologists were usually the last to see such cases, since in 95 per cent. of the cases the skin lesions were secondary. In this case the skin condition was secondary to a process which had its origin in the mouth, probably at the site of a carious tooth. Secondary cutaneous lesions also occurred in primary actinomycosis of the lung. Here, unlike tuberculosis, the process did not stop at the pleura, but penetrated pleura, bone and any tissue that came in its path, and finally appeared on the skin of the chest wall. The same remark applied equally to actinomycotic skin lesions of the abdomen; they were usually primary around the cecum and involved the cutaneous surface secondarily by direct extension. Referring to the mode of entrance of the organism of actinomycosis into the tissues, many believed (and in this group were to be found the authors of late textbooks on dermatology) that it gained entrance through the agency of splinters and straws. Another group of observers held the view that the organism existed normally in the gastro-intestinal tract, and that it became pathogenic only when the tissues suffered an injury. The patient had always been a city dweller and there was no history of having used straws or splinters. A remarkable feature of these cases was that rarely, if ever, had pathologic alterations been observed in the lymph nodes. Referring to this apparent immunity in lymphoid tissue, Dr. Fraser said that

some years ago he had examined a series of tonsils in which organisms were found in the crypts which morphologically were very much like the organisms seen in this case, but there was no tissue reaction, the organisms apparently living in symbiosis with the tonsillar tissue. Dr. Fraser demonstrated the presence of the ray fungus in sections taken from the skin lesions and the characteristic type of reaction to its presence in the tissues. He then showed the jaw of a mountain sheep, illustrating extensive bone necrosis.

Dr. Clark agreed with the diagnosis, and said that these cases were rare. He recalled one shown some time ago before the Academy, the Dermatological Section, in which the lesions were in about the same locality as in this instance, but extended toward the crease of the nose. They had the characteristic induration all around them, and little fistulae showed some discharge, but nothing like that seen in blastomycosis, with its little papillomatous finger-like projections and pus welling up between them on pressure.

Dr. Howard Fox agreed with Dr. Clark that the members were indebted to Dr. Fraser for presenting this rare case in such a complete manner.

Dr. Lane called attention to a recent article in *The Journal of the American Medical Association*, Aug. 25, 1923, by A. H. Sanford, in which the geographical distribution of this condition was worked out. Dr. Lane had had one case, a private patient, in Connecticut. Dr. Fraser's case was a typical one, and was very well developed.

Dr. Whitehouse said that reports of these cases were particularly rare in dermatologic societies; he did not know how frequent they were in other circles. He did not remember a case being presented before this Society, although he thought there had been one, and it was gratifying to see one with dermatologic lesions. He did not know much about the therapy of the condition, or whether pushing the iodids would have any effect on it. The Society was indebted to Dr. Fraser for the thorough way in which he presented this case and demonstrated conclusively that it was an actual case of actinomycosis.

Dr. Highman said the case was especially interesting because the man was a native of New York and had not been exposed to actinomycosis in any of the supposed ways. He then told of a woman who had two lumps on the left side of the neck, which looked like soft gummas or the lesions of sporotrichosis, but examination of the contents of which showed the ray fungus; there was no involvement of the jaw, but she had pyorrhea, and it seemed as though this were the portal of entry. This idea seemed to bear out Dr. Fraser's statement regarding the etiology of the disease in his patient. As to treatment, he agreed with what had just been said by Dr. Wise. Dr. Highman said that in some instances as much as 1,000 grains (65 gm.) of iodin had been given in a day.

A Case for Diagnosis. Presented by Dr. Clark.

Mrs. F. W., a woman, aged 47, born in the United States, a housewife, two years before presentation, developed an itching eruption all over the body. She insisted that the itching seemed to have begun some time before the eruption, that when the eruption appeared there was never much tendency to ooze, but that the skin seemed to be inclined to become thick and leathery. For the first year, the eruption was better and worse, but during the past ten or twelve months it had been quite constantly present over the whole body, and the itching had been severe. The patient perspired considerably, and during the fall had felt the cold a great deal. She had lived a moderate, temperate life, and was of about normal weight at the time her trouble began. No little plugs had been

seen on the backs of the fingers, and the diagnosis of pityriasis rubra pilaris could not be made. The case seemed to be a chronic indurated eczema and was submitted to have that diagnosis confirmed or denied. When first seen, the skin of the entire body was inflamed, distinctly thick and indurated, not in patches, but a rather universal thickening. During the past ten months almost every known method of treatment had been tried, including dietary, Roentgen-ray, glandular and local applications, and alkalis had been pushed with arsenic, with little or no improvement. Under a restricted vegetable diet, the patient lost 20 pounds (9 kg.), but during the past two months under a more generous vegetable diet, 15 pounds (6.8 kg.) had been regained. During the past six months she had lost considerable hair, and during the past six weeks or two months a few scattered, small, circumscribed nodules had made their appearance on the extensor surfaces of her forearms. As the patient lived in the country, it had thus far been impossible to obtain a blood count for blood chemistry or even a section for biopsy. The urine from time to time had shown a slight increase in indican, but had been normal otherwise. The patient said she would consider herself in pretty good general health were it not for the intolerable skin condition. The question of a possible leukemia of the skin and mycosis fungoides had of course been considered.

DR. CLARK asked for therapeutic suggestions.

DISCUSSION

DR. WISE said the eruption was of the type called pruritus with lichenification, by Brocq. The presence of small nodules in the skin suggested leukemia cutis, or possibly mycosis fungoides. He thought that a biopsy of the nodular lesions would give information.

DR. SCHWARTZ agreed with Dr. Wise that a further study of the blood and a biopsy were necessary to make the diagnosis.

DR. WHITEHOUSE agreed with the previous speakers, and said he thought that it was more than a generalized eczematous condition; he did not see any resemblance to pityriasis rubra pilaris; the few keratoses on the phalanges were such as might be found with any inflammatory itching condition of the skin. He could not think of anything except mycosis or a leukemic condition. The blood picture would probably give more information than a biopsy.

DR. BECHET said he thought the condition was eczematoid, possibly of leukemic origin. He would not class it in the "femme rouge" type, as suggested by Dr. Wise. He preferred to confine the use of that term to pityriasis rubra pilaris.

DR. KINGSBURY said he agreed with Dr. Fox. He thought that the condition would probably prove to be mycosis fungoides.

DR. HIGHMAN said that he also thought that "femme rouge" could be ruled out, and asked whether in connection with what Dr. Fox had said one would be warranted in ruling out mycosis or leukemia on a negative blood picture. The woman might be in a so-called leukemic condition, and one could not always rely on the histologic picture at a given moment, as it varied at different stages of a disease, sometimes being characteristic histologically and sometimes not, subject to the transient phases of the process. Clinically, no diagnosis suggested itself except that the condition might be roughly grouped under the classification of cutaneous lymphatic disturbance.

DR. CLARK said that the suggestions made by Dr. Sherwell had already been thoroughly tried over a much longer period than two or three weeks. The patient

lived in the country, and it had been difficult to observe her except at intervals, although he had been in touch with her husband over the telephone. She was uncomfortable when wearing her clothing, and suffered a great deal from the cold. He intended to continue the study of the case and would have a biopsy made of one of the nodules; those on the arm had developed in the last few weeks; in the spring there were no nodules. He had thought of mycosis fungoides and a leukemic condition of the skin, and would have had reports concerning these conditions had it been possible. He thought she was now beginning to realize the seriousness of the condition and would submit to further tests.

Dr. Howard Fox said he thought it more than likely that the blood and histologic findings might be entirely negative. This would not definitely rule out the possibility of mycosis or leukoplakia, but for the present one could not be sure of a diagnosis and could only speculate as to the possibilities.

Dr. Lane said he thought that one should obtain rather positive findings from histologic examination of the tumors.

Dr. Highman agreed, and said he had merely raised the question as to what to do should the findings prove negative. One should be able to confirm the diagnosis of one of the three conditions.

Pemphigus of the Mucous Membranes. Presented by Dr. Fox.

E. M., a woman, aged 60, a widow, born in the United States, first noticed an eruption in the mouth two years before. The lesions had appeared successively on the buccal mucosa, the palate and pharynx. Redness of the left eye appeared seven or eight months before, and a vulvar lesion a week before. The lesions in the pharynx had disappeared (under treatment); the others had remained in approximately the same locality. They were decidedly sore to the touch and occasioned considerable discomfort after eating almost any kind of food. Examination of the mouth showed an eruption on the soft palate, the pillars of the fauces and posterior portion of the buccal mucosa. The patches were fairly well defined and presented in places a whitish, shiny membrane, with highly inflammatory red borders. No bullae were noted. As to whether the lesions began as bullae, the patient was unable to state. False teeth had been worn for the past fifteen years, with the exception of the past eight or nine months, when they had been discarded in the hope of lessening the local irritation. There was a moderate injection of the palpebral conjunctiva of the left eye, and on the left labium majus was a nail sized red and tender superficial ulceration. A smear showed the presence of staphylococci and streptococci, but no fusiform bacillus or spirilla. A culture made at another laboratory showed a "profuse growth of *Streptococcus viridans* and a slight growth of pneumococcus, type IV and of *Staphylococcus aureus*." The patient was a short woman, weighing about 100 pounds (45 kg.). Although she had lost 60 pounds during the past year she appeared to be fairly vigorous and in good general health. She had been given arsenic for several months (drops) and numerous local applications had been made. Previous to the appearance of the eruption she had not taken any form of medicine for many years, except an occasional compound cathartic pill (once a month).

DISCUSSION

Dr. Bechet agreed with the diagnosis and said that in the past three or four years he had observed three or four patients with bullous lesions on the mucous membrane of from one to three years' duration. Lesions later developed on the

body, and death ensued within a few months from a generalized pemphigus. One of the patients was a woman, and, as in Dr. Fox's case, she had had lesions in the mouth and on the vulva for two years before they appeared elsewhere.

Dr. Lane agreed with Dr. Fox that pemphigus was a possibility, but that only time could decide whether or not this was the condition.

Dr. Whitehouse said he wished to corroborate the testimony given by Dr. Bechet, for he had a similar case in which the patient had lesions in the mouth which he thought at first were those of stomatitis or bullous erythema multiforme. Vincent's sign was negative; but subsequently the condition developed into a generalized pemphigus with lesions of the vulva and conjunctiva. He did not think the tooth could be blamed for the local infection, and while the lesion in the mouth did not look like pemphigus he would be very suspicious of it, and he thought more lesions would develop.

Dr. Wise said he thought the case was by no means typical of pemphigus. Most cases of pemphigus occurred in persons who were more or less run down and looked sick, and this woman did not look sick enough to have pemphigus. Of course that was a poor argument, for it might be a very early case, but he had received this impression, and he would be very cautious in making a diagnosis before watching the patient a long time. His general impression was that the condition might turn out to be pemphigus, but that no positive diagnosis could be made until further developments occurred in the disease.

Dr. Bechet said that two of his patients were in good condition and seemed perfectly well, with the exception of having a few bullae on the oral mucous membrane; yet in three or four months both patients had died of a generalized pemphigus.

Dr. Clark said that two years previously he had presented before the Society an emaciated woman, with all her teeth removed and ulcerations in her mouth. The general opinion of the Society at that time was that it was a case of pemphigus of the mouth. The lesions were extensive, involving the hard and soft palate, cheeks, gums and tongue, and the question of feeding was a serious one with her. She was thin and in bad condition, probably because she could eat little. He referred to this case in order to show what arsenic medication could do in a case like this. This patient had improved very much under treatment with Pearson's solution; whereas when the arsenic medication was stopped and the woman was sent away to the country for six or eight weeks, she promptly lost weight, the lesions in the mouth became worse, and she had pains and was unable to eat. She could be given 70, 80 or 90 drops of Pearson's solution, and the lesions would improve promptly; the patient would gain in weight, the mouth would be more comfortable, and she could eat soft food, mush, etc. That test had been made a number of times in the clinic during the past four years and the patient responded every time. The most marked case of pemphigus he had ever seen, that of a young boy, was seen at the Skin and Cancer Hospital. Most of the physicians agreed with the diagnosis of pemphigus. After a year under prolonged vegetable diet and intensive medication with arsenic and iron —sometimes by hypodermic injection and sometimes by Pearson's solution—the lesions disappeared and the patient became apparently well. He had been extremely active in college for the past three years. It had been almost four years since he had had any eruption. Dr. Clark had been much interested in the reports made from a St. Louis clinic of the case of a man treated by cacodylate of iron and coagulin. It seemed that iron and arsenic had a tremendous influence on these patients. Arsenic administered to the limit of tolerance had

been brought to his attention by Dr. Whitehouse years ago, and he had seen many patients at the hospital improve tremendously and their eruptions clear up, at least temporarily. He now felt that a case of pemphigus, unless the patient was dying of sepsis, was not a hopeless proposition, and the remedy was well worth trying. Unfortunately, there was no place in the hospitals for cases of pemphigus; no hospital wants to take a case, for the superintendent and nurses object to caring for such patients. At the present time, there were five cases in Dr. Throne's service at the Skin and Cancer Hospital that had to be treated as ambulatory patients, and who were being given cacodylate of iron and coagulin.

Dr. Whitehouse said that it had recently come to his attention that a colleague reported that patients with pemphigus all died during the attack. There had probably been a mistake in diagnosis in the cases of those who recovered; and he wished to stress what Dr. Clark had said. In a case which he had been observing since last April, in which the diagnosis had been verified at Mount Sinai Hospital, the patient was treated by dietary measures, and arsenic was pushed to the limit of tolerance. It was a case of generalized pemphigus of the skin and mucous membranes of the mouth, esophagus, gastro-intestinal tract, vagina and vulva, and it was thought the case was going to end with secondary pneumonia. At present the woman was well. Of course, she might have another attack, but although such patients often died under treatment, there seemed to be a difference in them; and because a case was diagnosed as generalized pemphigus was no reason why one should throw up his hands and get ready to sign a certificate of death. Every effort should be made in every case.

Dr. Bechet expressed himself as much interested in what had been said by Dr. Clark and Dr. Whitehouse, as he had had a private patient referred to him by Dr. Throne, with the diagnosis of pemphigus. The lesions were typical of that disease, yet a perfect recovery had been made after some months of arsenical and other treatment.

Dr. Highman asked the race of the patient. By exclusion, he thought the case sugested pemphigus, with the restrictions which Dr. Wise had expressed. Dr. Whitehouse had alluded to a series of thirty-two cases reported by Dr. Goldenberg, in which every variety of treatment had been tried, and in which with the exception of one patient all had succumbed; he did not think that at Mount Sinai they would agree with Dr. Whitehouse. In the series referred to, the disease had existed for from a few months to six and eight years before the patient had died of the disease, although in a good many instances there were remissions of greater or less duration. The generalization in the main still held true that pemphigus was practically always a fatal disease, in spite of the fact that isolated cures were reported in the literature. He would not go so far as to say that if a patient recovered he did not have pemphigus; for he knew the patient referred to by Dr. Whitehouse. The woman certainly had had what was considered as pemphigus, and she evidently had recovered from the disease or the attack. It was very well to say that if a patient recovered the condition was not pemphigus; but he did not understand why any disease should have a mortality of 100 per cent. Nevertheless, so far as the Mount Sinai cases were concerned, that was the fact. His personal experience led him to have nothing favorable to say in regard to arsenic therapy, nor had he, judging by the few cases in which it had been used, any enthusiasm for the coagulin treatment. The woman to whom Dr. Whitehouse had referred had had the coagulin treatment, and although she was alive, he was not sure that it was due to the coagulin. She was going to die, and she had had every variety of treatment suggested for pemphigus. He had seen cases that started in the mouth and on

other mucous membranes, lesions which persisted for two or three years before the patients died, people who looked as though they were in perfect health, so that the suggestion that this patient did not look sick had little weight. The serious phase came with the dissemination of the hypothetical toxicity; the patients then began to look sick. A lesion on the conjunctiva was not unusual in pemphigus. It was undoubtedly true that, all in all, most patients with pemphigus died of the disease; a few did not reach the serious stage of the disease until after several years, and some patients with cases that must be considered pemphigus possibly recovered, but he had never seen one do so.

Dr. Howard Fox said that a few years ago he would never have dreamed of making a diagnosis of pemphigus limited to the mucous membranes. During the past few years, however, he had seen a number of cases in which the lesions were for a time confined to the mucous membranes, the patients apparently being in good health. While he made the diagnosis in this instance with some hesitation, he was inclinded to consider it correct. As for drugs, the patient asserted that she has not taken any medicine for years except compound cathartic pills occasionally. Regarding the tendency of pemphigus to be found in the Jewish race, he would say that this woman was not a Jewess. He intended to try the treatment recommended by Dr. Davis of St. Louis.

A Case for Diagnosis. Presented by Dr. Wise.

R. G., a girl, aged 6, presented a pigmented lesion of two months' duration on the left cheek. There was no history of any previous lesions. A sister said that the child had been taking a preparation which contained phenolphthalein. There were no lesions elsewhere.

DISCUSSION

Dr. Howard Fox said that a peculiar feature about the lesion was the presence of a distinct infiltration.

Dr. Whitehouse asked whether there was a history of any inflammatory lesion preceding this one. It looked like a nodule following an inflammatory condition of some kind; it seemed to be softening in the center, and felt almost as though there was some pus there now.

Dr. Wise said that the history was negative for any preceding inflammatory lesion.

Lupus Erythematosus. Presented by Dr. Wise.

Mrs. M. L., aged 42, born in Russia, came to the Vanderbilt Clinic on Nov. 10, 1923. She presented a lupus erythematosus of the face which had been present for thirteen years. Three weeks before presentation she experienced a burning sensation on both sides of the tongue, anteriorly. The left buccal mucosa showed an irregular, superficial ulceration containing several small nodules.

DISCUSSION

Dr. Clark said he thought that the ulcerating lesion in the mouth was interesting; the edges were undermined, and it looked like an active tuberculous lesion. He had become fairly well convinced that lupus erythematosus was not necessarily a part of tuberculosis, and he always felt a little disturbed when he found lupus erythematosus and an active real tuberculous lesion somewhere

else in the body. Presumably, there could be two distinct and separate lesions in the same subject. The lesion in the mouth was in all probability a tuberculous lesion.

Dr. Whitehouse called attention to the fact that a bad tooth came in contact with the lesion. He said that this might cause some of the disturbance.

Dr. Wise said that lupus erythematosus seemed to be the most probable diagnosis, because the patient had had a superficial excoriation of the tongue on the opposite side to the buccal lesion, leaving a distinct atrophic patch on the tongue. The outline was sharply defined, and he was of the opinion that the condition was lupus erythematosus of the tongue, as it certainly was of the face; it was natural to infer that the present lesion was lupus erythematosus, but to say it was acually so was difficult without a biopsy examination.

Xanthoma Tuberosum. Presented by Dr. Bechet.

M. H., a boy, aged 3, presented lesions which had existed since he was 1 year old. The lesions were most extensive and of a general distribution; they were most numerous, however, on the arms and legs. They were quite small and rather uniform as to size. The characteristic color was present. A chemical examination of the blood and urine had been made, but the report had not as yet been received.

DISCUSSION

Dr. Clark said he had recently seen in the clinic the most remarkable example of xanthoma diabeticorum he had ever observed. The patient had lesions all over his arms, legs and buttocks, extensive and exuberant tumors, some of which had even ulcerated and crusted. The blood chemistry showed 520 mg. of sugar, and the carbon dioxid combining power was very low, only 26. He was in a bad condition and had been admitted to the hospital and put on insulin treatment, and there had been a marked improvement in his condition, the blood sugar being practically normal after two days' treatment with insulin. He hoped later to present the patient before the Society, for it would be interesting to note what effect the treatment would have on the xanthoma. He agreed with the diagnosis of the case presented.

Dr. Highman said that insulin was said almost invariably to cure this condition.

Dr. Sherwell said that he had shown some of the earliest cases of xanthoma diabeticorum presented before the Society. Dr. Johnson and Dr. Robinson saw them; the lesions were marked, and especially accentuated on the nates. There were three or four cases shown. They usually came in groups, and he had two cases at one time which were studied seriously by the two men mentioned, who were better posted than he as pathologists. That was over thirty years ago, and he believed they were the first cases recorded before the Society.

Dr. Kingsbury said that he had read one of Dr. Sherwell's reprints, and remembered very well his description of the appearance of the lesions.

Syringoma. Presented by Dr. Wise.

M. K., a woman, aged 34, who came to the Vanderbilt Clinic on Nov. 17, 1923, had an eruption which had been present for the past fifteen years and which was located on the trunk and arms, and was especially marked on the chest and abdomen. The lesions consisted of shiny papules varying in size from 1 to 4 mm. in diameter, which were violaceous to slightly yellowish brown. Some showed a tendency to become confluent. There were no mucous membrane lesions. The Wassermann reaction was negative.

DISCUSSION

Dr. Whitehouse said it would be interesting to know whether Kromayer light would be effective.

Dr. Fraser said that clinically the case was typical.

A Case for Diagnosis: Lupus Erythematosus or Boeck's Sarcoid. Presented by Dr. Bechet.

J. G., a man, aged 40, born in the United States, said that the lesion began six months previously. There were no subjective symptoms. On inspection, a lesion about 1 inch (2.5 cm.) in diameter was discernible on the left cheek. It was somewhat rounded, with sharply defined infiltrated borders. The central portion was much flatter, slightly scaly, and contained patulous glandular ducts plugged with keratotic matter. The whole area presented more of an inflammatory picture than one would expect in sarcoid, yet the induration was extremely noticeable, and nearer the usual boardlike feel observed in sarcoid.

DISCUSSION

Dr. Clark said he was inclined to agree with the diagnosis of lupus erythematosus. The man had been covering the lesion with salves, so that the typical scales with prolongations usually seen were not present; but the atrophy that accompanies lupus erythematosus was there.

Dr. Whitehouse did not know whether or not the patient had been treated with carbon dioxid snow. There was still an inflammatory edge, telangiectasis, etc. Whether or not it had been treated with carbon dioxid snow, a discoid lupus erythematosus could have that amount of scarring and infiltration, and he agreed with that diagnosis clinically.

Dr. Bechet said that the patient had had no treatment with the exception of a bland ointment and a little tincture of iodin, which the patient had applied before coming to the clinic. On close inspection one could easily see the hyperkeratotic follicles, scaling and the raised sharply marginated border so frequently observed in lupus erythematosus. The border was not sufficiently indurated to conform to granuloma annulare. He had been a little uncertain as to the differential diagnosis between lupus erythematosus and sarcoid, but he was inclined to consider lupus erythematosus as the more plausible diagnosis.

Generalized Lichen Planus. Presented by Dr. Wise.

Mrs. S. G., aged 52, Austrian by birth, came to the Vanderbilt Clinic on Dec. 1, 1923. She presented an eruption of three weeks' duration on the trunk and extremities. The eruption consisted of pinhead-sized erythematosus papules, some discrete and some confluent. The papules presented a shiny violaceus appearance, and were polygonal in shape, some showing a tendency to slight scaling. There were no mucous membrane lesions.

Parapsoriasis en Plaque. Presented by Dr. Wise.

I. D., aged 56, married, came to the Vanderbilt Clinic Dec. 13, 1923. The past history was negative. The duration of the present condition was two years. The lesions consisted of numerous well defined circular and oval plaques on the thighs and legs and to a lesser extent on the upper extremities, varying in size from one-half to 2 inches (1.2 to 5 cm.) in diameter. They were pinkish with a slightly yellowish tinge. There was no itching. The condition looked

like psoriasis from which the scales had been removed, but according to the history, there had never been any scales. There was no evidence of seborrhea in the usual locations. The Wassermann reaction was negative.

Dermatitis Venenata. Dr. Highman.

Dr. Highman made an informal preliminary report on an interesting case of dermatitis venenata. Two weeks before a woman came to the office with an eruption on the eyelids and on the left side of the neck and hands, which looked like ivy poisoning. She said that her sister had a similar eruption, although it was not so intense. On going over the events of the previous two days, when she and her sister had done the same things, it was found that they had both played mah jongg with a new set recently imported from China. He had, however, recalled an article in the Archives of Dermatology and Syphilology in connection with rhus poisoning and Japanese lacquer, and it occurred to him that this case might be due to lacquer. Various percutaneous tests made from scrapings from the ivory and bamboo pieces and from the lacquered case were made. Those from the ivory and bamboo gave negative reactions in both patients, but all of the preparations from the lacquered substances gave positive reactions—in the first woman, intense reactions. Some of the lacquer, dissolved, was painted on her skin and covered with adhesive plaster, which was removed in twenty-four hours. Typical local dermatitis venenata developed. The tests had been made on four patients, with positive results in two and suspicious results in one.

Presentation of Ringworm Cultures. By Dr. Howard Fox.

Cultures and hanging drop preparations were presented from two cases of ringworm of the scalp in adults. Case 1, M. B., a colored woman, had previously been shown by Dr. Scheer, and Case 2, A. G., a colored man, had been presented by Dr. Fox. The culture from Case 1 showed *Microsporon lanosum* and from Case 2 *Microsporon audouini*. The cultures were made on Sabouraud's isolation medium, American glucose having been used in place of maltose, now unobtainable.

NEW YORK ACADEMY OF MEDICINE, SECTION ON DERMATOLOGY AND SYPHILIS

Regular Meeting, Jan. 2, 1924

Paul E. Bechet, M.D., *Chairman*

Yaws. Presented by Dr. Howard Fox.

E. T., a colored girl, aged 10, was previously presented at the November meeting of the New York Dermatological Society with a case for diagnosis (bromoderma or yaws). Subsequently, the lesions on the face had increased in extent in spite of the fact that she had discontinued taking "cough medicine." The Wassermann test was strongly positive and several examinations of the lesions, after removal of crusts, showed moderately numerous spirochetes (of *Spirochaeta pallida* type). The diagnosis of bromoderma was apparently incorrect, and the evidence favored yaws rather than syphilis.

DISCUSSION

Dr. Goodman said that the lesions presented by the patient were typical of the cases of frambesia which he had seen in the tropics. Reference to recent papers from the Philippine Islands would show pictures of similar lesions in patients with yaws. This patient was the second one with tropical yaws shown in this city. The other was that shown by Dr. Howard Fox last year, which was probably the first case of frambesia tropica diagnosed in New York City. Last year, the members of the Section had the opportunity to view a case of frambesiform syphilis shown by Dr. Charles M. Williams. At the time of presentation, Dr. Klauder of Philadelphia was present. With Schamberg, he had only a short time previously observed a soldier with yaws, who had acquired the disease in France. Klauder gave a detailed account of the method of differentiating yaws from syphilis; and a consideration of the technic of differentiating the spirochetes of yaws from the spirochetes of syphilis. The inoculation method, using the eyebrows of susceptible monkeys first with the spirochetes of syphilis and then with the spirochetes of the lesions of suspected yaws, was excellent if one had the facilities for such work. Dr. Goodman had considered it possible to differentiate the spirochetes after staining by Giemsa's method. Under dark-field examination the spirochetes of syphilis and of yaws defied differentiation, and staining made a difference in that the spirochetes of syphilis maintained their integrity of form, coiled at the same height and as regular as under the dark field; but the spirochetes of yaws did not maintain their form with the same degree of regularity in the height or the contour of the coil. Ordinarily, too, it was difficult to demonstrate spirochetes from the lesions of generalized cutaneous syphilis; but all the lesions of yaws disclosed spirochetes if the smears were made after lifting the crust and using the serum from the underlying raspberry-like mass, the appearance of which gave the disease the name of frambesia. The Wassermann reaction was of no aid, as yaws was one of the diseases that gave a positive reaction; that is, a positive Wassermann test in the absence of syphilis.

Dr. Williams said that he had seen the patient before, and at that time had expressed the opinion that it was syphilis. Now, he was ready to change that diagnosis; the number of lesions, the character, and the contour were much more like frambesia.

Dr. Fox said he was not quite clear whether or not Dr. Goodman agreed with the diagnosis.

Dr. Goodman said that clinically the condition was yaws.

Argyria. Presented by Dr. Scheer.

X. Y., a man, aged 50, born in Russia, a teacher, first noticed discoloration of the skin five years before. For two years before that he had been taking silver nitrate by mouth for some gastric condition. The exact amounts could not be ascertained. The discoloration first appeared on the face and hands and later on the rest of the body. The entire cutaneous surface was a dark slate color, most pronounced on exposed surfaces, such as the face and hands. It was also present on the buccal mucosa.

Majocchi's Disease or Tertiary Syphiloderm? Presented by Dr. Parounagian. (Previously presented at the Manhattan Dermatological Society.)

M. B., a woman, aged 52, married, born in the United States, was admitted to the Bellevue Clinic on July 2, 1920, with practically no history except that

she had had a tracheotomy performed five years previously and that she had a rash on her extremities of about six years' duration; she also had a four plus Wassermann reaction. The eruption was symmetrical, confined to the forearms and legs, papulocircinate in character, dark brownish, and did not itch or pain; at times it was paler than at others. The Wassermann reactions had ranged from four to one plus, except on two occasions on which they were negative (total number of Wassermann tests, sixteen). The total number of injections consisted of the following: arsphenamin, nine; neo-arsphenamin, ten; silver arsphenamin, thirteen; mercuric salicylate, thirty-three. Iodids were also administered. The patient was shown twice at another society, and no definite diagnosis was made. A biopsy was made on Nov. 21, 1923, through the courtesy of Dr. Dresel, Dr. Ewing's report was as follows:

"The lesion presents the features of a chronic granuloma, affecting all portions of the derma. It consists of a lymphocytic and plasma cell infiltration of the blood vessels and about the dermal glands, which are thickly sheathed by these cells. At many points the lesions are larger, and in addition to the round cells there are many larger pale, ill-defined polyhedral cells, some of which fuse to form small giant cells in the centers of the lesions. These nodules strongly resemble miliary gummas. In a few places there is beginning necrosis in the centers of the nodules. Tubercle bacilli could not be found in sections. Levaditi's stain was not employed because of inadequate material. The appearances of the lesions are consistent with or even definitely indicative of tertiary syphilis."

DISCUSSION

Dr. Chargin did not think it was Majocchi's disease. Although the lesions were circular, they did not show the telangiectasia at the periphery, nor the atrophy which should be present in a case of such long duration. On these grounds he could not agree with the diagnosis of Majocchi's disease, although he could suggest no other diagnosis.

Dr. McCafferty agreed with the diagnosis of Majocchi's disease. It agreed somewhat in description with the case reported by Dr. MacKee. The lesions were angular and showed telangiectasia at the periphery with the appearance of atrophy in some of their centers.

Dr. Wolf said that he was interested in the micropathologic picture, if he understood the notes correctly; these said that the histology showed typical syphilis. How do you then explain the diagnosis with the pathologic picture? If it was Majocchi's disease, it should not have the earmarks of syphilitic pathology; if it were a syphilitic condition, there should be a change and according to the notes there was no change under antisyphilitic treatment; therefore, by elimination, the histopathologic diagnosis must be wrong.

Dr. Williams said he did not think it was either Majocchi's disease or syphilis; what it was, he did not know. It lacked the distinct atrophy, and he did not see the redness he would have expected; there was not the infiltration that occurred in late syphilis, and there had been no improvement under treatment. The only thing that suggested itself was a very old lichen which was somewhat raised; many of the papules on the legs had somewhat the appearance of lichen. He would like to see the case in daylight and have another specimen examined.

Dr. Fraser said he thought that the clinical features and the fact that the condition had not yielded to antisyphilitic treatment suggested Majocchi's disease. The histologic report of the case did not make any reference to the

characteristic endarteritis or ectasia. If this was a case of Majocchi's disease, these changes in the vessels should have been noted. He had seen so few cases that he was not prepared to offer a clinical diagnosis.

DR. BECHET said he had not noted any atrophy, but there was an apparent annular distribution of dilated blood vessels which he had not been able to press out with his finger. Vigorous antisyphilitic treatment had had no effect on the lesions. In view of these facts, he was inclined to agree with the diagnosis in spite of the fact that there were no discernible telangiectatic spots.

DR. RULISON said a point had been made of the fact that the patient had received antisyphilitic treatment without improvement. If this was pigmentation following a syphilid, one would not expect that to improve under treatment.

DR. PAROUNAGIAN said that he had presented this case twice before at the Manhattan Dermatological Society, and no definite diagnosis had been made. Majocchi's disease was the only suggestion made that seemed probable. The lesions were the same as when first seen, i. e., circinate, purplish red macules accompanied by pigmentation. When talking with the patient in the afternoon, she said that last summer the condition almost cleared up. She had received a great deal of treatment, as stated in the history, and had shown no improvement so far as he could see. She had no subjective symptoms. A section of the skin was given to Dr. Satenstein, whose report had not been received. Further study would be made of the case, and perhaps it would be reported further.

ATROPHY WITH TELANGIECTASIA. Presented by DR. ANDREWS.

The patient, a woman, aged 22, born in Russia, presented an eruption of five years' duration, gradually progressive. On both breasts and on the inner surface of the thighs was a mottled erythema with marked telangiectases. Within these lesions were numerous atrophic lines. On the dorsal surfaces of the hands and elbows the skin was cyanotic and telangiectatic, and a similar condition existed in the flush areas of the cheeks. There was brownish, patchy, pigmentation on both shins. The scalp was diffusely erythematous with nummular areas of atrophy. There were evidences of dyspituitarism. The glucose tolerance was normal.

DISCUSSION

DR. ANDREWS said that Dr. Wise had suggested the diagnoses of atrophy with telangiectasia, acrodermatitis atrophicans and lupus erythematosus; but the most probable diagnosis was atrophy with telangiectasia.

ACQUIRED SYPHILIS IN A CONGENITAL SYPHILITIC. Presented by DR. PAROUNAGIAN.

D. D., a colored girl, aged 17, born in the United States, unmarried, was admitted to the Bellevue syphilis clinic on December 28, with a history of exposure on July 4, 1923; about three weeks later she had a breaking out over the entire body for which she obtained some medicine and salve from a drug store and cured herself. About three weeks before presentation an eruption appeared, first on the face, and gradually extended to other parts of the body, including the genito-anal regions. The eruption on the face consisted mainly of circinate lesions characteristic of annular syphilid; the lesions on the body were rather sparse and of a nodular type. The genito-anal regions exhibited numerous condylomas and there were mucous patches on both tonsils. Further examination revealed typical hutchinsonian teeth and

"tubercle of Mibelli" on the first molars, and other evidence of heredosyphilis. Her father had been dead several years. He had had a large sore on the middle of the right leg, which never had healed. Her mother was living, 49 years of age, and was said to have had heart disease with high blood pressure. A Wassermann test had been made, but was not yet reported. The patient was presented on account of the positive symptoms of acquired secondary syphilis with interesting annular syphiloderm of the face and strong evidences of congenital syphilis.

DISCUSSION

Dr. Kingsbury said he did not think the patient's teeth were especially characteristic of hereditary syphilis.

Dr. Rulison said that the central incisors were narrower on the cutting edge than at the base, and that the cutting edge was concave. The second upper molars on both sides showed a fifth tubercle. The teeth changes seemed characteristic of congenital syphilis; he did not know of any other condition in which they were found together, and that they were as good evidence of congenital syphilis as Hutchinson's teeth would be.

Dr. Williams disagreed with Dr. Rulison about the pegging of the teeth; he would not call them pegged—they were distinctly notched; but he could not see that they were any narrower at the cutting edge than at the top.

Dr. Abramowitz said that he had no doubt that a patient with congenital syphilis could also acquire the disease anew, but he would hesitate from the appearance of the upper central incisors of this patient to class her as having a case of congenital syphilis. He examined the upper and central incisors closely; they showed only a notching of the edges. There was no rounding off of the angles; they were not dwarfed; they were not rounded or peglike; they were not improperly placed, and the edge of the tooth was not narrower than the gingival border. The enamel was also perfect. Aside from the caruncles of Mibelli on her molars and the high arched palate, no definite stigmas of congenital syphilis were present.

Dr. Parounagian said that the majority rules, and the majority were against his diagnosis. He would be very glad to have the gentlemen lay down rules telling how one could prove that a patient had congenital syphilis—the notch was not in the center, or not a typical shape, etc., and the high arch or imperfect hairline was not definite. How would they prove it? These stigmas were present in the patient; the patient also said that the father had had a large ulcer in the middle of his leg that never healed, and which one might consider a syphilitic gumma. Of course if it was claimed that this girl was perfectly healthy, and if there were no other symptoms, his diagnosis was wrong; but he had considered this a case of congenital syphilis, and had so presented it. In his opinion, one could not expect to find certain exact symptoms. From what he had seen, he knew the patient's teeth were not normal, and he believed the case to be one of congenital syphilis. The father was dead; the mother was living, and 49 years of age, with high blood pressure and heart disease. The cause of the father's death was not known. The girl had every indication of being a congenital syphilitic. Dr. Parounagian would obtain the mother's history and Wassermann reaction, to ascertain if possible the question of heredity, and would report further.

Dr. Howard Fox said he did not think the evidence in this case was sufficient to establish the diagnosis of acquired syphilis occurring in a congenital syphilitic. The case, he thought, was not proved.

LICHEN ATROPHICUS. Presented by DR. WALZER for DR. LAPOWSKI.

R. M., a woman, aged 23, married, who had two children and who had had no miscarriages and was never sick, had a condition that began two years before; the first lesions appeared on the neck. Scattered over the entire body, especially in the axilla, and forearms and at the elbow, were numerous fine pinhead sized, pinkish white or almost white, shiny lichen papules, some on the level of the skin, some slightly elevated, some with slight depressions in the center. In some locations, especially the forearms, they were arranged along scratch marks or in groups. On the front of the chest and neck was one large area composed of many pea to penny sized patches, round, white or nacreous, polycyclic, slightly depressed, some wrinkled, and sharply outlined. On the thin epidermic lining of many of these spots could be seen dark pinhead sized granules in the follicular openings. Many of the individual patches or spots were bordered by normal skin, but the border of some of these patches had some of the lichen lesions that were on the rest of the body. The skin on the neck and upper part of the chest between the atrophic spots was hyperpigmented. There were no lesions on the mucous membrane.

DISCUSSION

DR. CHARGIN agreed with the diagnosis, but what seemed to him especially interesting in this case were the lesions that were present on the arms and shoulders, which were not unlike those seen in lichen nitidus. They were small papules, of the color of the skin, and closely crowded together. A patient shown some years ago by Dr. Parounagian, which was typical of lichen nitidus, presented lesions very much like those observed in this case.

DR. HOWARD FOX said he did not think any of the lesions were similar to those he had seen in two undoubted cases of lichen nitidus.

DR. LEVIN said that when he first observed the patient's forearm he had thought of lichen nitidus and had asked if anything had been done to the forearms; but in view of the duration, the lesions on the neck and the atrophy, one would have to accept the diagnosis of lichen atrophicus.

DR. WALZER replied that he had never seen a case of lichen nitidus that involved the entire body and produced atrophic areas as in this particular case.

SYNOVIAL CYST. Presented by DR. SCHEER.

This case was previously presented at the Manhattan Dermatological Society.

ANGIOMA SERPIGINOSUM (PROVISIONAL DIAGNOSIS). TWO CASES IN SISTERS Presented by DR. WILLIAMS.

The father and mother of these children were not related. They had six living children; no dead children; and no miscarriages. The two patients were the third and fourth child, respectively. The child, now 6 years old, was normal at birth except that there was a "clot" at the vertex of the scalp. A crust formed, and the entire mass had fallen off, leaving a scar which was still present. The child was perfectly normal otherwise, and no further cutaneous blemishes were known to have been present. The child did not have any teeth until 1 year of age. The bowels were always loose. At the age of 18 months the mother noticed a rash on the face, which was thought to be a "teething" rash. The eruption persisted. The hands, legs, buttocks and other parts were

involved at an early but unnoted age. The child had had varicella. She was always underweight, and at one time the entire condition including that of the skin was diagnosed by a consultant as "malnutrition." No treatment had been effective. The fact that the eruption either spread or ceased to spread had never been noted by the parents. The child now 4 years old: The birth was normal. There were no cutaneous blemishes until at the age of 18 months, when a "teething" rash appeared, at first only on the cheeks but later on the buttocks, forearms, arms, hands and legs, including part of the dorsum of the feet. There had been no spreading, according to the mother. The child had had parotitis and varicella at 2 and 3 years, respectively. There was no alteration of the cutaneous surface after remission of the varicella, which was severe. The child had always been underweight, suffering with diarrhea, and nocturnal enuresis. Her mentality was normal. There had never been any subjective symptoms. The roughening of the skin of the buttocks was said to be the result of the child's uncleanliness. The hair, teeth and nails of both children were normal. The other four children were normal. The youngest, aged 16 months, had an eruption of the skin which appeared at intervals, and had also a teething rash, according to the mother. All of the children had always lived in the suburbs. No member of either the mother's or father's immediate family had any disease comparable with that of these two children. The eruption on the cheeks, forearms, arms, buttocks, legs and feet of these two children was made up of a dilated vascular element which faded on pressure; there was some pigmentation; there was little thickening (except on buttocks of the younger child) and a distinctly mottled appearance, even when the child was not subjected to cold. There were no lesions comparable to the cayenne pepper spots on the periphery of the large lesions. The diagnosis taken up were: angioma serpiginosum, Majocchi's disease, essential telangiectasis of Stokes, xeroderma pigmentosum and a disease of which no more could be learned than its name—livedo racemosa. The children came to the hospital on December 28; one child became ill and was not seen again until the evening of presentation. The younger child was seen the previous day, and a section of the skin was taken for microscopic study. Dr. Williams did not see the children at the clinic.

DISCUSSION

Dr. Abramowitz said that the presentation of the two sisters was interesting, but he had no definite diagnosis to offer. The eruption was present on the cheeks and hands and had been present for a long time, hence it might be a peculiar type of nevus. It showed a reticulated erythema, evidently of vascular origin, as on pressure the skin appeared to be normal. The question arose as to the type of the angiopathy; there was evidently no dermatitis present; the skin was not inflamed, not edematous and not infiltrated; on the legs was a typical livedo reticularis. In view of these points, it was possible that the condition was a congenitally increased growth or dilatation of the subpapillary vessels coming not under the classification of telangiectasia, but of reticulated angioma.

Dr. Howard Fox said he could not see many of the seven points of diagnosis described by Dr. Wise as characteristic of angioma serpiginosum. There were merely numerous telangiectases, many of which were in the form of circles. He could not classify the condition except as one of the group of telangiectatic diseases.

Dr. Fraser entered an objection to the use of the term angioma in these cases, and others of a similar nature. To meet the condition required by the

term angioma, there would have to be a new growth of vessels in the neoplastic sense, that is, new vessels growing without regard to the laws governing the distribution of such vessels. There was no evidence of any such growth in these cases; therefore he suggested recording them under the name telangiectasia serpiginosum.

URTICARIA PIGMENTOSA. Presented by DR. WALZER for DR. LAPOWSKI.

M. C., a girl, aged 5 years, had a condition that started when the child was 3 months old. She was first seen about six weeks before presentation. At present she showed over the entire body, face and extremities, numerous scattered millet to half dollar sized spots of dark red to brown. Some of the lesions were brown in the center, surrounded by erythematous but not sharply outlined borders. These lesions looked first as if they were surmounted by lichen papules, but on closer inspection it was seen that there was no lichen, but the skin over these lesions was puckered and folded, which gave this lichen appearance. The wrinkled surface could be flattened out or pinched out. All the glands were enlarged.

DISCUSSION

DR. WALZER: Replying to a suggestion that it might be a phenolphthalein eruption, he said: 1. There was no history of any drug ingestion. 2. The child had been under observation for about six or seven weeks, and the lesions were practically the same as when first seen. 3. The lesions as described above were not simple erythematous spots as might be seen after ingestion of phenolphthalein, but many of them were puckered, evenly distributed and symmetrical over the entire body. They itched, and on irritation showed their urticarial elements. 4. The child had had this eruption since she was 3 months of age.

ERYTHEMA MULTIFORME BULLOSUM. Presented by DR. SCHEER.

W. G., a man, aged 23, born in Germany, presented himself at the Mount Sinai clinic, with an eruption of five days' duration. He had had two similar attacks, one two months before and again a month before. On the dorsal surfaces of the forearms, extensor surfaces of the thighs, and here and there on the trunk were a moderate number of circular violaceous elevated patches, from ¼ of an inch to an inch (0.6 to 2.5 cm.) in diameter. They were surrounded by a faint red halo, and were depressed in the center. Several of the lesions were of the iris form, showing two rows of rings, one within the other. There were typical herpes iris lesions on the mucosa of the lips. On the gums, mucosa of the cheeks and hard palate and tongue were numerous erosions partially covered with a grayish white exudate, the sites of ruptured bullae. On the glans were several vesicles and bullae, the largest one-half inch (1.2 cm.) in diameter. They were quite tense and appeared at the same time as the other lesions. These lesions on the glans were situated on a normal skin. There was not the slightest evidence of erythema surrounding these lesions.

DISCUSSION

DR. SCHEER said the man was first seen at the Mount Sinai clinic that afternoon, and gave a history of having had these lesions for only a few days, but that he had had three outbreaks previously.

HYSTERICAL GANGRENE. Presented by DR. WALZER for DR. LAPOWSKI.

H. S., a schoolboy, aged 17, was mentally defective. He was the third child of seven; the others were normal. He had had the usual diseases of infancy. There was no history of the use of any drugs, either internally or externally, and no history of any trauma. When he was 11 years of age, he had had the first "convulsion." This was preceded by pains all over the body, headaches, etc., which lasted for a few days. He went to bed and stayed there for one week. The "convulsion" was bilateral without frothing at the mouth and with total unconsciousness. These attacks occurred every two or three months and were always preceded by some definite symptoms. The present condition began about eight months before, after an attack of "convulsions." After one week in bed, blisters were noticed on both heels, soon followed by gangrene, which was not very painful. Five or six months before he had had a similar attack, and similar lesions were noticed on the buttocks. From two to three months before, the patient had another attack, with the same lesions on the buttocks. From three to four weeks before, another attack occurred and was followed by lesions on the left upper thigh and left ankle. At present, he showed: (1) on both heels, quarter dollar sized, punched out, gangrenous ulcers, with sharply outlined borders and centers filled with necrotic cores (remains of the lesions that had occurred eight months before); (2) on the right upper thigh, laterally, and at the top of the spine, two elongated scars, keloid-like, the remains of lesions present five or six months before; (3) on the right buttock, near the spine, one elongated ulcer 2½ by 1½ inches (6.2 by 3.8 cm.), hard, indurated, with sharp edges and a base covered with hypertrophic granulations, the remains of lesions that had been present three months before; (4) (*a*) on the left upper thigh, laterally, one erythematous patch, surmounted by a number of serpiginous ulcerations, not very deep; (*b*) on the left ankle, inner surface, one serpiginous ulceration, about 1 inch across, sharply outlined, with a moist base. These lesions were three weeks old. The hair and nails were normal. Neurologic examination revealed numerous areas of anesthesia over the entire body and exaggerated reflexes. The urine was negative and the blood showed an eosinophilia of 6 per cent.

DISCUSSION

DR. WILLIAMS said he thought the boy had hysteria; he had a well recognized nervous condition—the areas of anesthesia, the mental condition, the convulsions, were probably all hysterical. He did not know whether the history stated that these areas of necrosis occurred in the areas of anesthesia. It seemed to be a pure case of self-inflicted lesions such as one often sees in these hysterical cases. The fact that you could see it develop was no proof that it was not; the patient would have to be watched by a nurse day and night, and even then he might elude her vigilance.

DR. WOLF said that Dr. Walzer had brought out an important point, viz., that the boy had had convulsions—that was probably epilepsy. The fact that he was of low mentality and the history of convulsions would suggest the possibility of an eruption from bromid ingestion.

DR. MCCAFFERTY suggested the possibility of these lesions being trophic ulcers from tabes, and advised lumbar puncture. The patient had several areas of anesthesia, and his patellar reflexes were exaggerated.

DR. HOWARD FOX agreed with Dr. Williams that the eruption was a self-

inflicted one occurring in a person with classic stigmas of hysteria. He could not agree with Dr. Walzer that the production of lesions on inconvenient portions of the body, such as the buttock and heel, would rule out the diagnosis of malingering. The ways of such patients were difficult to understand, as in a case he had recently seen, that of a pretty young woman who had caused disfiguring lesions on her face.

DR. FRASER said he did not understand why the term gangrene should be used to describe the lesions in this case. Gangrene means tissue death "en masse" from mechanically produced anemia. There was nothing in the clinical picture suggesting that condition. The destruction of tissue here was probably due to the action of bacteria.

DR. WALZER said that when the boy was first seen he had gangrenous areas, dollar sized and punched out on both heels. They were healing now. Those on the buttocks were either healed or almost healed. On the upper right thigh, lesions were observed developing. It began as an erythematous, slightly infiltrated, dollar sized patch, and a few days later vesicles were observed on this lesion. These vesicles then dried and gangrenous areas developed. As to the question "Why hysterical?" many of the members objected to the title. Dr. Walzer said that these lesions could be called "neurotic excoriations," "dermatitis gangrenosa," etc., but what he wanted to convey was that in his opinion these lesions were not self-inflicted, but occurred spontaneously and that such lesions were possible in a person whose nervous system was below par, plus a slight trauma. The question of drugs was raised. As far as the history could be relied on, no drugs had been taken for the last two years, with the exception of compound licorice powder. As to the suggestion of tabes: The boy had no organic disease of any kind and no symptoms of tabes. The only symptoms referable to his nervous system were those of hysteria, as were given in his history. It was suggested that these lesions were due to epilepsy, but Dr. Walzer said he believed the patient had never had epilepsy. The attacks were purely hysterical. The boy would select the time and place for the "convulsion." He never had them in the street, always in the house. He knew when they were coming, and at times could ward them off. He was not always completely unconscious during the attacks. As to the question whether these lesions were on anesthetic areas: The fact that the boy had large gangrenous areas on both heels and could walk apparently comfortably showed that he probably was deficient in sensation in those areas. As to the method of formation of these lesions, Dr. Walzer said that these hysterical persons have a peculiar sensitiveness of the skin which is not present in normal persons. It was suggested that they might be bedsores, but the boy had not been in bed long enough if those lesions were explained on the principle of pressure alone. But slight pressure of a week in bed in a hysterical subject whose skin was vulnerable could produce lesions of this nature. In other words, one must have a condition, such as a general weakness like that after a prolonged illness or a hysterical skin, plus pressure, to produce lesions such as were present in this boy. Dr. C. J. White, in a discussion of this subject some time ago, claimed that such lesions were possible from hysteria. He said that ordinary blushing, which was dilatation of the vessels, could be produced by external stimuli. If this were possible, why could not this dilatation go beyond a certain point and produce edema; and if continued further, necrosis and gangrene. In other words, it was not necessary to invoke outside aid or even suspect malingering when the condition could be explained from internal causes.

PSORIASIFORM SYPHILIS. Presented by DR. PAROUNAGIAN.

M. P., aged 30, single, an Italian, an iceman, reported at Bellevue syphilis clinic on Dec. 31, 1923, with a history of chancre six months previously; the period of incubation was three weeks. Six weeks after the appearance of the genital sore, he consulted a private physician, who administered ten "arm injections" and twenty injections into the buttocks. The last injection had been given one week before, and despite all the treatment he had received the lesions remained. The eruption was extensive, involving the entire body. The lesions were circinate, with fine scaly borders resembling psoriasis scales and with deeply pigmented centers. There were mucous patches on the tonsils and condylomas about the anal regions and marked adenopathy. On account of phimosis, the location of the genital sore could not be detected.

DISCUSSION

DR. PAROUNAGIAN said that he did not believe the treatment had anything to do with the pigmentation in this case; he had shown at least two cases of this class of pigmentary syphilid before the patient had received any treatment. The interesting point, besides being very well chiseled out, was the resistance to treatment. The patient said that he had had ten injections in the arm and twenty elsewhere, and he still had these manifestations.

DR. WILLIAMS said in his opinion the arsenic had nothing to do with the pigmentation; any secondary syphilid in healing would leave a pigmentation, and he would not call this a pigmentary syphilid; that, as he understood it, occurred on the neck as a broad area of pigmentation, dotted with pale areas; the term should not be applied to the pigmentation which was left after the healing of almost any syphilitic manifestation.

DR. PAROUNAGIAN took exception to Dr. Williams' statement, and cited a case in which the patient came in with the active stages of syphilis and with pigmentation. He had shown such cases at the section before the patient had received any kind of treatment; when this woman first came to the clinic she had pigmentation all over the body; it had nothing to do with the treatment.

IMPETIGO OF BOCKHART OR SYCOSIS? Presented by DR. PAROUNAGIAN.

E. B., a Greek seaman, aged 55, was admitted to Bellevue syphilis clinic on Nov. 20, 1923, with a history of a frenal sore twenty years previously, and a rather extensive follicular eruption of the entire lower extremities of four months' duration. His Wassermann test was reported negative and the lesions had failed to improve under mild applications like calamin lotion, boric ointment and mild white precipitate ointment.

DISCUSSION

DR. MCCAFFERTY quoted Sabouraud as saying that the impetigo of Bockhart was unfortunately named; impetigo of Bockhart is merely a staphylococcus infection confined to the hair follicles and should be classified under the name of sycosis vulgaris.

DR. SATENSTEIN said he did not think the condition was either sycosis or the impetigo of Bockhart; it was a severe dermatitis resulting from local applications.

Dr. Parounagian, after Dr. Satenstein's remark, said he knew nothing about that. The patient had been under observation for a month and a half and he was treated with mild applications like calamin lotion, boric ointment and ammoniated mercury ointment, 5 per cent., with very little change. The man was a seaman. He did not work in the engine room, but cleaned decks, etc. The lesions were follicular in character, confined only to the lower extremities and tallied to the textbook description of Bockhart's impetigo. He was hoping to receive some suggestions as to the diagnosis and treatment, as this was the most extensive case he had seen.

A Case for Diagnosis. Presented by Dr. Feldman.

D. D., a man, aged 33, married, born in Poland, a tailor, said that one and a half years before, he had developed pruriginous lesions about his chin. These were treated with the roentgen ray and the quartz-mercury lamp. When the lesions had cleared, depigmented patches remained in their place. Since then other pruriginous lesions had appeared. These healed spontaneously, with depigmentation. On the left side of the neck there was a patch 1½ by 2½ inches in diameter, the upper portion of which was vitiligenous. The lower half was pink. The color gradually increased as the border was reached. The latter was red and infiltrated, and occasionally a scale was present. On the right side of the neck, there was an irregular patch of vitiligo, which appeared to be made up of several confluent patches at the junction of which there was a semicircular narrow patch which was red and infiltrated. This appeared partly to encircle the vitiligo patch, and there were several small active lesions within the latter. There were several smaller patches of vitiligo with or without active lesions. The latter, when present, seemed to hug the border of the patch. One patch of vitiligo on the forearm, the patient said, was originally an actively pruriginous lesion. The biopsy showed a mild hyperkeratosis, elongation of the rete pegs, infiltration of the papillae and masses of round cell infiltration in the middle layer of the cutis. There was an absence of pigment, the collagenous bundles were thickened and sclerosed, and the elastic tissue was diminished.

DISCUSSION

Dr. Howard Fox said he thought it quite possible that the patient presented two distinct diseases, and that the patches of vitiligo might be independent of the inflammatory disease. To prove the relationship of the two conditions, it would be necessary to observe the eruption carefully for months and to note whether the vitiligo spots appeared in areas previously occupied by the dermatitis.

Dr. Williams agreed with what Dr. Fox had said, and added that another point was that one of these inflammatory bands ran across the border of vitiligo and seemed to be a separate condition.

Dr. Satenstein said he had not understood from the biologic, pathologic or clinical points of view how the inflammatory process could cause the vitiligo. There should be an atrophy, and there was none. In his opinion, the two conditions were independent of each other.

Dr. Abramowitz said that besides the leukoderma which he thought was secondary, the man presented serpiginous bands on the side of his neck, the bands showing quite an infiltration with nonmicaceous scaling; he also showed

nodular lesions in the mastoid region and on the scalp. Although the lesions were of comparatively short duration, the fact that there was considerable itching before the eruption appeared, with infiltration and figurate appearance of the lesions, favored the diagnosis of mycosis fungoides.

Dr. Feldman said the man gave a distinct history of an inflammatory patch on the chin which was followed by depigmentation after roentgen-ray treatment. One of the patches in the hairy region was covered with gray hair. Unfortunately, the light in the room was not very good. In daylight one could distinctly see the gray hair over the infiltrated patch. One patch was surrounded by a ring of vitiligo. Some vitiligo patches, on the other hand, were surrounded by inflamed margins. The band to which Dr. Williams referred as running across a patch of vitiligo was not that, but it was the margin of one of two confluent patches. This was easily seen from the manner in which the inflammatory band partially surrounded one of the patches. The biopsy was taken from one of the inflamed margins and there was not a vestige of pigment in the specimen. It was evident that the infiltrated patches themselves had no pigment. From that he concluded that all vitiligo patches were preceded by inflammation. There was no reason to believe that inflammation could not be followed by depigmentation. This was seen in lichen planus and psoriasis. The finding of elongated papillae and infiltration in the cutis made the case resemble psoriasis to some extent, but there was some evidence of atrophy, namely, some sclerosis of the collagenous bundles and a diminution of the elastic fibers. There was no resemblance to mycosis fungoides. The specimen lacked the generalized infiltration with cells which varied greatly in shape and size.

Epithelioma of the Palm. Presented by Dr. Parounagian.

B. T., a man, aged 62, born in Armenia, a rug doctorer, denied venereal history, and no evidences of it could be detected. He said that during the summer of 1923, while working in the garden, a blister formed on the palm of his hand, which he picked. The condition persisted, leaving a circular, superficial patch at the site of the blister. Examination revealed a superficial, circinate patch with a delicate pearly border. The patient did not complain of pain or itching, except as he described it as a "stretching feeling." The case was presented on account of the unusual location of the lesion. Since the history was prepared the patient had called attention to leukoplakia-like lesions in the mouth, which had existed long before the palmar lesion appeared. He was a heavy cigaret smoker, which might account for it, or there was a possibility of lichen planus.

DISCUSSION

Dr. Howard Fox said that the only diagnosis that occurred to him was a lichen planus annularis. The white patches in the mouth were also suggestive of lichen planus.

Dr. Parounagian said the only thing that made him think of epithelioma was that the lesion had a hard, firm, pearly border, and was of an extremely superficial type. It started after working in the garden in August; a blister formed, followed by the condition presented. It might well be a part of lichen planus. There was no itching on the palm and no venereal history. A Wassermann test would be made and the case watched. There did not seem to be any danger in holding it for a while.

LUPUS ERYTHEMATOSUS. Presented by DR. WILLIAMS.

F. M., a man, aged 27, a chauffeur, presented typical lesions extending over both cheeks, nose and forehead, with a rather unusual eruption on the upper lip. He stated that the lesions first appeared two years ago on the left cheek, and gradually spread, the eruption on the upper lip dating back one year. His past history was negative, with the exception of an acute fever of ten days' duration in October, 1923, which was diagnosed by the local physician as either pneumonia or an erysipelas (because of the condition on the face). Several Wassermann tests were negative at other clinics. He was presented to show the eruption on the lip and the difficulty in making a diagnosis in cases in which the vermilion border only was involved.

HERPES ZOSTER (WITH LESIONS ON BOTH SIDES OF THE NECK). Presented by DR. WILLIAMS.

A young man, an American, presented lesions most marked on the left side of the neck, shoulder and chest, typical of the condition. These lesions had first appeared on December 27, and had gradually increased in extent. On December 29, several lesions had appeared on the right side of the neck.

PEMPHIGUS VULGARIS. Presented by DR. WALZER for DR. LAPOWSKI.

M. B., a man, aged 35, married, a quilt maker, with the exception of having had influenza, had never been sick. There was no history of any chronic diseases or any skin diseases in the family. For the last year the patient had had frequent nosebleeds, with slight soreness in the nose. About two and a half months before, he noticed three crusted pea-sized lesions on the chest anteriorly. These had been increasing in number on the upper part of the body, face, mouth and scalp. At present, there were lesions on the following sites: chest, front and back, neck, face, scalp and right arm. The primary lesion was pea sized, flaccid, white and bullous with no areola. This soon became somewhat opaque or hemorrhagic and eventually dried up, leaving a dark brown impetigenous, thick adherent crust. The crust finally fell off, leaving an erythematous area. The patient showed marked dermographism, but on forcible pressure, the skin slid away, leaving a moist, oozing, reddish surface (Nikolski's sign). On the lower lip, soft palate, uvula, posterior pharangeal wall and inner lips were numerous pinhead to pea-sized bullae or broken down bullae. The Wassermann test was negative. The treatment had consisted of local applications and the injection of neo-arsphenamin intravenously.

URTICARIA PIGMENTOSA. Presented by DR. WALZER for DR. LAPOWSKI.

L. M., a young man, aged 18, unmarried, said that his present condition dated back seventeen and a half years, when he was 6 months old. He was first seen by Dr. Lapowski in July, 1908, when he was 2 years and 6 months old. At that time he showed xanthoma planum-like lesions over the trunk, extremities, face and neck. Many of these had become absorbed, leaving brownish pigmentation. This case was shown at the Section of Dermatology, Academy of Medicine, on Nov. 10, 1908, (*J. Cutan. Dis.* **27**:173, 1909) and again on Dec. 5, 1911 (*J. Cutan. Dis.* **31**:172, 1913) as a case of xanthoma planum. At both meetings, the diagnosis was not accepted, the majority favoring urticaria pigmentosa. On Feb. 8, 1917 (*J. Cutan. Dis.* **35**:555, 1917) he was shown again, this time as having a case of urticaria pigmentosa. With the exception of an attack of

scabies three weeks before, the patient had been well. At present, he showed scattered over the entire body and extremities, numerous pinhead to pea-sized brownish macules, not elevated, and not sharply outlined. He showed marked dermographism. All of the glands were enlarged.

GRANULOMA ANNULARE OF THE BACK OF THE LEFT HAND AND TINEA OF THE RIGHT AXILLA. Presented by DR. ABRAMOWITZ.

H. S., a woman, aged 24, unmarried, a factory worker, an Austrian by birth, who had been in this country for ten years, had an eruption of six years' duration, involving the knuckles of the left index and middle fingers. The lesions consisted of six pea-sized nodular infiltrations of the skin arranged in a circinate patch about 1½ inches (3.8 cm.) in diameter. She came to the clinic principally for a sharply outlined weeping and itching dermatitis of the right axilla of two months' duration, which resembled a dermatophytosis.

LICHEN PLANUS ANNULARIS. Presented by DR. ABRAMOWITZ.

L. A., a woman, aged 26, married, born in Greece, was referred from the Presbyterian Hospital Dispensary by Dr. Hopkins. According to the patient, the eruption had started fourteen years ago and had recurred from time to time. No definite data could be obtained as to the duration of the present lesions, but from their appearance, they had existed at least two years. There was a shiny papular and scaly eruption on the patellar region of the knees, with a few similar lesions on the flexures of the elbows and wrists. The ankles presented annular lesions varying in size from ¼ to ¾ of an inch (0.6 to 1.8 cm.) in diameter, and showed in some places typical shiny violaceous papules at the circumference. On the front of the left forearm was an irregular annular patch that showed a depigmented and atrophic center. There were no lesions in the mouth. She had had various and many treatments, including the roentgen ray, with very little benefit. She was told that her Wassermann test was negative. Unna's ointment was prescribed, and a biopsy would be performed and reported on at the next meeting.

ARSENICAL PIGMENTATION. Presented by DR. ABRAMOWITZ.

R. B., a woman, aged 28, who was married but had no children, had had the condition for three months. She had received twelve injections of silver arsphenamin, with no reaction. With the last three injections she noticed brown itchy spots, which had been becoming lighter in color since the treatment was stopped two months before.

COMPLETE DESTRUCTION OF PENIS IN A SYPHILITIC PATIENT. Presented by DR. PAROUNAGIAN. (Previously presented at the Manhattan Dermatological Society, November, 1923.)

H. S., a man, aged 34, single, a laborer, was referred to the Bellevue syphilis clinic on Oct. 29, 1923, for treatment of his syphilitic manifestations, which were a patch of nodular syphilis on the upper portion of the chest and extending over the left shoulder, a similar lesion at the pubic region and an ulceration at the base of the penis. The patient said that he never had had a genital sore, but he had had gonorrhea ten years previously. In 1917, an ulceration had started at the under surface of the penis, which had resulted in a fistula. The ulceration had progressed gradually, destroying a portion of the organ:

a little later another portion sloughed off, until finally the entire organ was destroyed about one and one-half years before. At no time did he consult a physician until recently he had retention of urine, for which he was admitted to Bellevue Hospital. His Wassermann report was four plus on Oct. 29, 1923; and since he had received several neo-arsphenamin and silver arsphenamin injections, which removed nearly all the cutaneous manifestations. He was inclined to be timid. His mental condition was about the same as that in two patients who had been under his care within the past two years.

GUMMA OF THE TESTICLE. Presented by DR. PAROUNAGIAN.

J. G., a man, aged 37, an Italian, married, reported at Bellevue clinic in December, 1923, with a history of a genital sore fourteen years before which had been treated with mercury injections only. On examination, the right testicle was found to be about four times larger than normal, firm and almost painless to the touch. The duration of the condition was said to be one month. His Wassermann test was reported four plus, and an injection of silver arsphenamin was administered on Dec. 20, 1923. His skin and glands were negative; the pupils reacted sluggishly, and the Rhomberg sign was slightly positive.

EPITHELIOMA OF TONGUE IN A TERTIARY SYPHILITIC. Presented by DR. PAROUNAGIAN.

P. F., a man, aged 66, an Italian, married, was admitted to the Bellevue syphilis clinic on Nov. 19, 1923, with a history of chancre forty years previously, and an ulceration of the right side of the tongue which was said to be of about three months' duration. He had extensive leukoplakia of the buccal mucosae and tongue, which was quite painful. His Wassermann test was reported three plus on Nov. 19, 1923, and three neo-arsphenamin and one mercury injection constituted his treatment to date. So far no improvement was discernible.

ANAL CHANCRE WITH SECONDARY SYPHILIS. Presented by DR. PAROUNAGIAN.

J. McD., a boy, aged 19, born in the United States, single, a dishwasher, denied sexual exposure but admitted sodomy. Three weeks after the incident, a sore developed at the anal regions. This was about one month before presentation. He came to Bellevue syphilis clinic on Dec. 31, 1923, with a moderate roseola, the remains of an anal sore and condylomas, general adenopathy, etc. A Wassermann test was being made on the afternoon of presentation, and no treatment had been administered.

GRANULOMA INGUINALE (CLINICAL DIAGNOSIS) AND SYPHILIS. Presented by DR. PAROUNAGIAN.

S. J., a colored man, aged 22, a seaman, born in the United States, reported at the Bellevue syphilis clinic on the afternoon of the presentation. He gave a history of a genital (frenal) sore six months previously. The incubation period was three weeks, and it was self treated locally. The condition for which he was presented was an ulceration in the inguinal region, which the patient stated had existed for ten months. The lesion in question was situated at the right inguinal region, a linear ulceration extending toward the pubic region and downward to the scrotal junction near the perineum. The man had been at the City Hospital recently, where twelve "arm injections" and nine

injections into the buttocks had been administered. He did not complain of pain or discomfort. He had marked phimosis and a thick greenish urethral discharge. The Wassermann test was made, but had not been reported on.

LUPUS ERYTHEMATOSUS CONFINED TO THE EYELIDS AND SCALP. Presented by DR. OCHS.

O. K., a man, aged 46, married, a native of Poland, first noticed the eruption on his scalp one year before. It appeared on his eyelids about the same time.

RECKLINGHAUSEN'S DISEASE. Presented by DR. OCHS.

R. M., a woman, aged 22, single, noticed the condition for the first time two and a half years before.

NEVUS VERRUCOSUS ZOSTERIFORMIS. Presented by DR. SCHEER.

G. G., a boy, aged 16, presented lesions which dated from the time he was 1 year of age. (The history was given by the father.) The most posterior lesions began when he was 1 year of age; the other patches at intervals of about one year. The two anterior groups had been treated with trichloracetic acid.

ERYTHRODERMIE CONGENITALE ICHTHYOSIFORM. Presented by DR. SCHEER.

S. L., a boy, aged 9, presented the condition in a generalized form since birth. There was no history of the same disease in the family. It showed the peculiar red glazed appearance of the face.

OSCAR L. LEVIN, Secretary.

ST. LOUIS DERMATOLOGICAL SOCIETY

Regular Meeting, Jan. 9, 1924

JOSEPH GRINDON, M.D., *Presiding*

A CASE FOR DIAGNOSIS. Presented by DR. JOSEPH GRINDON.

A white woman, aged 56, married, a housewife, was first observed on Jan. 8, 1924. Her past history recorded acute gastro-enteric attacks since the age of 17, less severe now than formerly. The last childbirth occurred sixteen years before; the menopause eight years later. The patient complained of "hot flushes," also of a severe sore throat seven weeks before presentation. The tonsils were not visible. At presentation there were skin lesions of four weeks' duration, with slight erythema and a slight mealy scaling of the face, especially about the temples and nose, the scalp showing branny scales. Other patches, generally symmetrically distributed, were situated on the lower part of the abdomen, ceasing above the inguinal fold, also on the forearms, hands, thighs, legs, feet and on each side of and above the cleft of the nates. The palms and soles showed a dry, thick epidermis, somewhat limiting motion. Elsewhere patches presented deep pink areas denuded of the upper layers of stratum corneum, showing papery scaling at the margins. There was no appreciable

infiltration. The blood examination showed: hemoglobin 68 per cent. Sahli, 12,400 white blood cells, 32 per cent. polymorphonuclears, 68 per cent. small mononuclears and no eosinophils. The blood pressure was 140.

DISCUSSION

Dr. Richard Kring said he thought the lesions were of endocrin origin. The differential blood picture suggested the possibility of a beginning leukemia, or the history of acute sore throat might indicate a toxic effect from tonsillitis. Further study and observation would determine the diagnosis.

Dr. Toomey said he was inclined to minimize the value of a single differential count. He considered it a case of toxic exfoliative dermatitis, secondary to a streptococcic sore throat, and would be inclined to consider it an aberrant case of erythema scarlatiniforme.

A Case for Diagnosis. Presented by Dr. Richard S. Weiss from Dr. Engman's Clinic at Washington University Dispensary.

L. H., a white woman, aged 24, presented skin lesions of four months' duration, consisting of granulomatous papules with necrotic centers and pigmented depressed scars in scattered groups on the face, arms and trunk. There were several larger granulomatous lesions on the thighs with central necrosis.

DISCUSSION

Dr. Kring said he thought it was a bromid eruption.

Dr. Toomey said he believed the lesions were tuberculids.

Dr. A. H. Conrad said he was inclined to believe that there was some necrotic scarring following the original lesions, such as is observed in necrotic tuberculids. He thought the patient's appearance, thin and gaunt, would indicate such a condition.

Dr. Kring said he thought the patient might be neurotic. She had taken "medicine for the nerves," which fact, together with the character of the lesions showing scarring in the center, might indicate the condition sometimes seen in a bromid rash.

Dr. Grindon said he had no positive diagnosis to offer, but was inclined to accept Dr. Kring's opinion that it was a bromid lesion plus the effect of traumatism from scratching, which in turn could cause the scarring.

Dr. Toomey added that the period of duration, i. e., four months, was against the diagnosis of a bromid eruption as the patient had been taking medicine all this time, which would tend to make the lesions larger and more extensive, as a bromid rash does not stop at such small lesions when the ingestion of bromid is continued for four months after the first appearance of lesions.

Dr. Conrad called attention to another case to be presented later, in comparison with which the present case showed an entirely different character. Although there are many different varieties of lesions associated with bromid eruptions, there seemed to be a greater profusion of them, especially after four month, than was presented in the case under discussion, which did not present the aspect of a bromid eruption.

Dr. Kring remarked that drug rashes have no particular region of attack, being found in one location in one person, and at another site in another case.

Dr. Toomey said that he had never seen a bromid eruption that did not attack the area over the shin bones or the outer or posterior aspect of the legs.

A Case for Diagnosis. Presented by Dr. Richard S. Weiss from Dr. Engman's Clinic at Washington University Dispensary.

A colored woman, aged 25, born in Alabama, claimed to have had an attack of a skin disease in 1922, from which she recovered after taking medicine for one month. The present attack began in November, 1923, the lesions appearing simultaneously, but not growing any worse. The primary lesion was a small flat plaque from 3 to 5 mm. in diameter, with a few plaques from 2 to 3 cm. in size. They were all raised 1 to 2 mm. above the surface of the skin. The tops of some were scaly, while others were smooth and shiny. The lesions were distributed thickly over the chest and upper part of the breasts, the upper part of the sternum, axillary folds, over the neck and behind the ears, with a few on the forehead and face.

DISCUSSION

Drs. Toomey and Greiner diagnosed the case as seborrheic dermatitis.

Dr. Grindon suggested lichen planus atrophicus. On the right breast was a group of about five lesions which were distinctly polyangular, the lesions consisting of flat papules, rather dense in structure, except the oldest ones which showed some atrophy. The arrangement in striae about the root of the neck was sometimes noted in lichen planus.

A Case for Diagnosis. Presented by Dr. W. Porter Brown, Barnard Free Skin and Cancer Hospital, service of Drs. Engman and Mook.

A. F. M., aged 57, four months before noticed a soreness inside the nose. When he blew his nose, "plugs" were expelled. The soreness increased, and an ulcer appeared which spread until it included the lower margin of the ala nasi, the septum, an adjacent area on the upper lip and an area on the end of the nose the size of a twenty-five cent piece. There was also a small ulcer on the left side of the nose, and one in the midline separate from the larger area. The ulcers were rough and crusted and seemed to contain many abscesses. They were not very painful, but bled easily when crusts were peeled off. The entire nose was erythematous and symmetrically enlarged. Some of the erythema was probably due to the effect of Roentgen-ray therapy, the last treatment having been received about three weeks before presentation. Slides made from the crusts and exudate showed no encapsulated bacilli. Sodium hydroxid preparations were negative. The patient stated that his Wassermann reaction was + + + +. The results of the blood examination have not yet been reported from the laboratory.

DISCUSSION

Dr. Greiner and Dr. Kring thought it was a tuberculous type of syphilis.

Dr. Toomey said he felt that the diagnosis lay between tuberculosis verrucosa cutis and blastomycosis, more probably the latter, depending for positive diagnosis on clinical observation and microscopic examination.

Dr. Grindon called attention to the papillomatous character of the nodular lesion, which, with the fact of a duration of only four months, constituted convincing points in the diagnosis of syphilis.

Dr. Brockelmann diagnosed the condition as late syphilis, as syphiloderma frambesioides.

Dr. Conrad concurred in this diagnosis. He recalled that blastomycosis had been mentioned when the patient was first examined, but that blastomyces are usually observed at the outer border of the lesion, whereas in this case the pus expressed was not around the border but from around the central part of the lesion of the nose. In blastomycosis the honey-combing and pustular area is around the edge of the lesion, which condition was not seen in this patient. Judging from the history of the case and its general appearance, he felt justified in making a diagnosis of tuberculous or nodular syphilis.

A Case of Late Nodular Syphilid. Presented by Dr. A. H. Conrad from Dr. Engman's Clinic at Washington University Dispensary.

E. S., a man, aged 30, married, presented serpiginous, ulcerating areas with central depressed scarring on the outer surface of the left arm and on the calves of the legs. The condition began ten months previously. The patient denied venereal infection. He had had a right orchidectomy three years ago for injury to the testis, and an appendectomy eight years before. The Wassermann report was not available.

DISCUSSION

The consensus of opinion was that this was a case of syphilis.

Dr. Grindon concluded the discussion by calling attention to the simultaneous occurrence of the resolutive and ulcerative types of nodular syphilis; the resolutive or psoriasis-like type on the shoulder and the ulcerative type on the legs.

A Case for Diagnosis. Presented by Dr. T. J. Calhoun from Barnard Free Skin and Cancer Hospital, service of Drs. Engman and Mook.

M. H., aged 29, had been injured in an automobile accident six months before presentation, her leg having been penetrated by a spoke, the wound remaining unhealed. The patient began taking bromid for insomnia three months before, from 120 to 180 grains (8 to 12 gm.) daily. About one month ago, an eruption appeared over the face and back which was papular and papulopustular in character. About that time an ulcer appeared on the anterior part of the right leg, which, when first observed, was punched-out and worm-eaten in appearance, exuding a seropus. There was extensive crusting. The surrounding skin was red to violaceous and very tender to the touch. All of the ulcers were exquisitely painful. The Wassermann and spinal fluid tests were negative.

DISCUSSION

All concurred in a diagnosis of bromoderma.

CHICAGO DERMATOLOGICAL SOCIETY

Regular Meeting, Jan. 16, 1924

E. A. Oliver, M.D., *President, in the Chair*

A Case for Diagnosis. Presented by Dr. Senear.

A Jewess, aged 41, who had had an active stomatitis of severe degree which had been present for a year, one week before presentation developed dermatitis

about the forearms, face, back and legs. She had received treatment with tampons of glycerin and iodin, and some simple mixture had been prescribed by the department of internal medicine at the Illinois Medical School. There was a questionable history of her having received bromid at one time.

The lesions were bullous, with a scanty purulent discharge when the patient was first seen a few days previously. A weak ammoniated ointment had almost cleared up the pyogenic element.

DISCUSSION

Dr. Eisenstaedt said he thought the lesions suggested a bromid eruption rather than any other type of eruption.

Dr. McEwen said he was inclined to lean toward a diagnosis of a drug eruption, and he thought it might be due to iodin. The lesion on the left thigh were distinctly acneform, and there was a history of the use of vaginal tampons of iodin.

Dr. Foerster said he thought the discussion would have to center around a diagnosis of dermatitis, ecthyma and pemphigus. The lesions were superficial, began as bullous lesions, appeared to have healed rapidly, and there was at present an erosion on the right buccal mucous membrane of rather large size in addition to the smaller lesions on the floor of the mouth and beneath the tongue. These, in connection with her race, required consideration in connection with pemphigus. The heavy crusting of the lesions on the legs and about the elbows he thought could very well be ascribed to secondary pyogenic infection. Such lesions were seen in pemphigus. He believed that further observation would be necessary before a diagnosis could be established.

Dr. Mitchell said he thought the diagnosis lay between a bromid eruption and pemphigus. There was a lesion on the left shoulder that was bullous and on a nonerythematous skin, which he thought should be taken into consideration. The erosion in the mouth made one hesitate to exclude pemphigus.

Dr. Waugh said he was impressed with the case as resembling bromid eruption, but he thought from the appearance it was also suggestive of syphilis.

Dr. Senear said he had thought of the three conditions mentioned by Dr. Foerster, and he was particularly interested in the possibility of pemphigus because of the frequent reports of patients with lesions of the mouth for a year or more before any cutaneous symptoms developed. This patient had had an intractible stomatitis for a year or two, and thorough examination by internists as well as by nose and throat specialists failed to reveal any cause. The new lesions were violently inflammatory, with a good deal of pus, but the ready response of that element to applications of weak ammoniated mercury solution and the great improvement manifested within a few days made him believe this was a secondary factor in the case. He believed the diagnosis lay between a bromoderma and pemphigus, although the profuse eruption in the mouth suggested a pemphigus very strongly. The skin lesions did not suggest this so much. The intrascapular lesion was the most suggestive of bromoderma.

Note.—The patient later developed typical pemphigus and died in about eight weeks.

Urticarial Eruption with Angioneurotic Edema. Presented by Dr. Eisenstaedt.

A woman, aged 39, had a disorder that had been present for several years, manifesting itself periodically with enormous lesions of angioneurotic edema of

the face and forehead, associated with urticarial lesions over the body and extremities. These outbreaks apparently had no relation to the type of food taken and no etiologic basis could be determined. Skin tests with all groups of proteins had been negative. The basal metabolism rate was greatly increased, being 25.6 per cent. above normal. The case was shown as one of urticaria and angioneurotic edema, possibly belonging to a group described by Dr. Strouse as due to hyperthyroidism.

DISCUSSION

DR. SENEAR said he was impressed with the fact that the condition suggested a solid edema following lymphangitis in the nose, but the statement that the disorder began with an acute noninflammatory attack, did not fit in with this picture.

DR. ORMSBY said he considered the case interesting in demonstrating what Dr. Eisenstaedt had said, that these patients had been treated empirically with thyroid whether thyroid was indicated or not. In this case thyroid therapy probably would have been injurious. He had thought of solid edema of the face, but he believed this condition could be ruled out.

DR. MCEWEN said that although the patient had a plus metabolism rate, he was not convinced that the condition was related to the thyroid gland, but he was inclined to consider some unexpected article of food as a contributory factor. He had such an experience in a case of urticaria in which practically everything exept butter was excluded, without results; when butter was withheld the disorder cleared up; which proved an unsuspected food to be the cause of a severe and persistent urticaria. In his opinion, this patient might be highly sensitive to some simple article of food.

DR. EISENSTAEDT said he thought Dr. McEwen hit the nail on the head when he said that in spite of the high basal metabolism rate, the thyroid pathology might possibly not have anything to do with the urticaria, and that all protein sensitization tests should be thoroughly canvassed. At the dispensary the patient had been tried out [illegible] protein sensitization clinic with all the groups, with no reaction. He was particularly interested in the fact that the basal metabolism should deter one from exhibiting thyroid in a case in which there was already too much thyroid, whether or not it was producing the disease. He thought that many of these patients should have an opportunity of being carefully examined in other than dermatologic clinics. This patient was receiving thyroidectomized horse serum at present. If on this therapy, with no other change, she remained free from an attack for six months or a year, he thought it would be worthy of note.

VACCINIA, FOLLOWED BY IMPETIGO. Presented by DR. WAUGH.

A girl, aged 6, whose disorder had been present since October, 1923—three months—had a history of vaccination at that time by the school physician. The vaccination was successful, but the wound never healed and became infected. A discharge had been present for about two weeks after the vaccination, and the infection had gradually spread and involved the face and hands.

On the left arm there was a large oval area with marked redness and weeping, crusting and some edema, as well as marked infiltration. The actual site of the vaccination presented a raised area the size of a dime, which was red and raw looking, with weeping and crusting. The lesions on the face were impetiginous. On one shoulder there was a typical vaccination pustule which had been present for two weeks. A similar lesion on one thumb healed after three weeks, leaving a scar.

DISCUSSION

DR. SENEAR said he was not certain that the diagnosis of vaccinia was correct. The lesions were decidedly vegetative in type, and he believed that a vegetating staphylococcus might possibly account for the whole picture.

DR. ORMSBY said he thought the condition was a pyogenic infection which produced the vegetating lesions in the local area and the impetiginous lesions elsewhere. Generalized vaccinia occurs in two forms, one through general infection, the other and more common through auto-inoculatoin of the virus. In the case presented it appeared that the lesions were the results of auto-inoculation of pyogenic organisms rather than vaccinal virus.

DR. WAUGH said he thought it was a mild case of vaccinia, but that most of the lesions were impetiginous in character. The lesion on the shoulder had been present for two weeks, and he considered this a typical vaccination pustule. The lesions had been present on the thumb for three weeks, and as they healed they left scars. Similar lesions had been present on the neck. He believed that the ordinary lesions of impetigo do not last so long, are not so deep seated and do not leave scars. The child had a mild eruption when she was vaccinated, and he thought the point should be stressed that children should not be vaccinated at such a time.

A CASE FOR DIAGNOSIS. Presented by DR. MCEWEN.

A man, Polish, aged 41, a tailor, whose disorder had been present for four years, thought the lesions started on the inner aspect of the thighs, but he did not remember what their appearance was at first or how rapidly they had spread. He thought they had remained about the same since he first noticed them. He had never had pain, tenderness or itching in the lesions; there was no history of syphilis. He complained of an infection of the left big toe of two months' duration, accompanied by tenderness and pain, and also of "rheumatic pains" in the joints of the left side, of the same duration. The general history was negative except for a diagnosis in the genito-urinary department of chronic prostatitis and seminal vesiculitis. The blood Wassermann reaction on Dec. 26, 1923, was negative.

Lesions were present on the legs, thighs, hips, penis and lower part of the trunk. They were discrete, varying in size from that of a pea to a dime. On the back nodular lesions were seen, with some induration. The color varied from a whitish to a purplish hue. There was no visible scaling or erythema. The lesions apparently resolved, leaving atrophic, superficial scars, which were best seen on the inner aspects of the thighs and were of a purplish hue. A large scar of this type was present on the foreskin. In addition, there was a frank infection on the left big toe and a large scar in the left upper quadrant of the abdomen, the result of an old burn.

DISCUSSION

DR. ORMSBY said he thought the condition was a form of atrophy of the skin first described by Schweninger and Buzzi under the title "Multiple Benign Tumor-Like New Growths of the Skin," an example of which had been described first in this country by Pusey. The early lesions are bladder-like formations which on undergoing involution leave flaccid scars.

DR. SENEAR agreed that this case came in that group. The lesions are due to loss of elastic tissue, and as the atrophy progresses they become slitlike scars.

Dr. Senear called attention to the case of a colored girl who was shown by Dr. Weber and himself last year. Dr. Pusey saw that case, and he said he thought it was one of multiple benign tumor-like new growths, which was the consensus of opinion when the patient was presented before the Dermatological Society, except for Dr. Waugh, who thought it was a case of Recklinghausen's disease. They took out one of the large lesions and found that while there was loss of elastic tissue, the lesion had definite fibromatous tissue. There had been much discussion as to the multiple tumor-like new growths as an entity, and it was thought that they might be Recklinghausen's disease. This did not hold true of the original case shown by Dr. Pusey.

Dr. Senear was inclined to the belief that the case presented was one of multiple tumor-like new growths with elastic tissue degeneration, which might follow various causes.

Dr. Ormsby said he thought there were well defined lesions in this case. In the macular atrophy following pneumonia or typhoid fever, the lesions had a different outline, usually striate, while in this disorder they were oval or rounded, and there was some underlying process which was not accidental. He thought some of the lesions resembled one type seen in Recklinghausen's disease, and Crocker said a number of years ago that he had seen such lesions follow the absorption of cutaneous fibromas. Whether it was an entity or not, he did not know. He believed the cases reported by Dr. Pusey and others were of a similar nature, but that their exact position remained to be demonstrated.

Dr. McEwen said he was interested to know whether or not the disturbances of the toe could be regarded as related to the other conditions. He thought it had not taken the course of an ordinary pus infection.

Lupus Erythematosus. Presented by Dr. Stillians.

A Jewish housewife, aged 42, first noticed a small red spot on the left ala nasi eighteen months previously. This slowly increased in size, without any objective sensation.

At the time of presentation nearly the entire left ala nasi was covered by a bluish red erythema, rather sharply defined, much deeper in color toward the tip of the nose and paler near the nasolabial furrow, with dilated venules in this portion. This paler area had appeared recently, whether as a result of natural evolution or of ultraviolet light therapy, was not known.

DISCUSSION

Dr. Eisenstaedt said he did not believe that one could make a diagnosis of erythematous lupus from one examination. He had noticed no evidence of scaling and suggested a diagnosis of nevus.

Dr. Mitchell said he could not decide whether or not the erythema was due to the treatment, but he thought it might be a mild rosacea with an erythema due to the quartz light.

Dr. Waugh said he believed it was a chronic inflammatory condition, possibly infectious in character. He had seen a number of cases of folliculitis in the nares, in which the lesions would clear up occasionally. He thought it was probably a chronic infection of the nasal passages with the redness extending through to the surface.

Dr. Ormsby asked whether the redness was due to the recent treatment with the Kromayer lamp.

Dr. McEwen said he did not think it was a case of erythematous lupus, but he had no diagnosis to offer.

Dr. Foerster agreed with Dr. McEwen that it probably was not an erythematous lupus. He said he could not make out any definite limitation of the lesion, that it faded out gradually, and he thought that probably some change had been produced by the treatment that did away with a clean-cut picture of the original disorder. The history stated that at some time a single small red papule had been present, and he asked whether this lesion could be a nevus.

Dr. Stillians said that he made the diagnosis of lupus erythematosus because he did not know what else to call the condition. The patch had been present all the time for the last year, sometimes being more pronounced than at others. He thought the lesion now was a little larger than it had been and the color a little more pronounced. He had never been able to make out any distinct papular lesion, and it was not like any other case of lupus erythematosus that he had seen. He recalled a similar case of sharply defined erythema on the nose which he saw some years before and which he could not clear up in any way.

Ulcers of the Lips. Presented by Dr. Liebertiial.

A man, aged 42, the father of six healthy children, had ulcers on his lips. His wife aborted after her first conception, but all the subsequent ones had ended at full term. He had always been in good health, except that for the last two years sores had occurred at intervals in his mouth, which healed promptly. During the last two months an ulcer had developed on his upper and one on his lower lip, which were growing larger and causing him considerable pain. During the same period he suffered from profuse nightly perspiration and had lost considerable weight.

On the lower lip, just behind the vermilion border and near the left corner of the mouth was a somewhat oval, shallow ulcer the size of two beans in apposition. Its margins were well defined, not quite round, not infiltrated and in places undermined. The base of the ulcer was irregularly eroded, with slight secretion. On the upper lip was a similar ulcer of about the same size, which was in close contact with the former when the mouth was closed.

The Wassermann reaction on his blood was negative. A general examination, especially of his lungs and an examination of tissue from the ulcers and animal inoculation were to be made and reported at a subsequent meeting.

DISCUSSION

Dr. McEwen said he thought it was probably a case of tuberculosis.

Dr. Ormsby agreed that this was probably a case of tuberculosis of the mucous membrane, a condition which was of rare occurrence here. In view of a history of loss of weight and the painful character of the ulcer, he was inclined toward this diagnosis. The only cases he had seen had been extremely painful, a symptom he believed to be characteristic of tuberculosis of the mucous membranes of the mouth and throat.

Dr. Waugh was reminded of a case seen some years ago, with a lesion of the lower lip which was chronic and inflammatory in character. Four different diagnoses had been offered: chelitis glandularis, lichen planus and lupus erythematosus, and Dr. Pusey was the only one who suggested malignancy. A section from that case showed typical basal cell carcinoma. Dr. Waugh thought it would be necessary to have a section of this case to prove the diagnosis.

DR. SENEAR said he was interested in the case because of one seen during the past month. He did not recall having seen tuberculosis of the mucous membrane before since his association with Dr. Pusey. The patient came in with a round lesion on the tip of the tongue which had been present for one month. He thought of a chancre, although there were no enlarged glands. The dark-field examination was negative. The lesion did not suggest tuberculosis particularly, but the next time the man came in, his physician had found advanced pulmonary tuberculosis, and at that time Dr. Senear found that the margin of the lesion, which appeared to slope down to meet the base, had a characteristic undermined margin of a tuberculous ulcer, although unless it was lifted up it gave no appearance of undermining. The lesion was not painful and did not suggest tuberculosis. He agreed that the case presented was tuberculosis of the mucous membrane, and he thought the specimens would also suggest this.

DR. LIEBERTHAL said he thought it was necessary to be careful about accepting a history of there having been a similar lesion which healed. He had seen the patient six months previously, when he had a follicular abscess on the tongue. He disappeared from observation and had presented himself again only a few days before. Dr. Lieberthal thought in the diagnosis consideration should be given to secondary syphilis, tertiary syphilis, epithelioma and Vincent's disease, which latter might occur independent of the throat. But all these could be ruled out. This case seemed to be one of tuberculosis. There was no time to examine the patient's lungs. He thought one should not be too optimistic about finding tubercle bacilli in the lesions. He promised to excise a piece and to inoculate an animal also and report further at a future meeting.

PITTSBURGH DERMATOLOGICAL SOCIETY

Regular Meeting, Jan. 17, 1924

STANLEY CRAWFORD, M.D., *Presiding*

NEUROFIBROMA. Presented by DR. WERTHEIMER.

A woman, aged 21, had presented the condition for the past fifteen years. There were for the most part pea-sized, freely movable, hard tumors situated in the subcutaneous tissue occurring on the palmar and lateral surfaces of the joints of the fingers, palms, left thenar eminence, dorsal wrists (here resembling ganglia), extensor elbows, over the crests of the ilia, on the knees, insteps and heels. In places such as the wrists they appeared to be attached to the tendon sheath and on the arm as though attached to the veins. The skin over the tumors was normal. The patient complained of the tumors being sensitive to touch and having neuralgic pains at times. Roentgen-ray examination of the hands was negative. There was no connection between the joints and the tumors. The bones were normal.

DISCUSSION

DR. HOLLANDER said he could not make a definite diagnosis and suggested that a biopsy be made. He said that Sergent's line was present in this case, a symptom usually seen in Recklinghausen's disease, neurofibroma and neuroma.

Dr. Phillips said he did not know what to call it; some of the lesions were connected with the tendon sheaths, while others were apparently connected with the nerve sheaths.

Dr. Crawford said he considered this a most interesting and unusual case and he felt that the diagnosis should be neuroma rather than neurofibroma. He believed the term neurofibroma led one to consider a Recklinghausen's condition, the stigmas of which were not present. The lesions were hard and quite tender, and he felt that some fibrous element was probably present in their structure. He at first believed that the hard nodes along the antecubital veins were of the same nature, but he now was satisfied that they were thrombotic processes from the "radium solution" injections she had received.

Dr. Wertheimer said that he did not present this case as one of the Recklinghausen type, but as a fibroma with nerve-sheath involvement. It was most interesting and unusual in distribution. He did not regard it as a neuroma as the tumors were freely movable and hard, and the color was not that of a neuroma. A biopsy would be made.

Note.—The biopsy report showed that "the structure was that of a neurofibroma with interlacing bands of fine fibrous tissue not unlike that of the nerve sheaths. The stroma substance was pale and delicate. A few lymphocytes were scattered here and there."

Lichen Planus. Presented by Dr. Phillips.

A. L., a man, aged 37, a glassworker, presented a more or less generalized eruption involving chiefly the hands, feet, scrotum, glans and shaft of the penis and buccal mucosa. This eruption was characterized by papules of a violaceous red color, pinhead to pea-sized, with central umbilication and slight scaling. On the dorsum of the left hand was one lesion of the hypertrophic type about 1 inch (2.5 cm.) long, one-quarter inch (0.6 cm.) wide and elevated above the surface about one-eight inch (0.3 cm.). According to the history, this lesion was the first to appear and has persisted throughout the eighteen years of the disease. Two doses of roentgen ray (½ skin unit, McKee) has almost caused the disappearance of this lesion. Itching has been the only symptoms of this disease, at times being very annoying. This case was presented on account of its chronicity and because of the multiplicity and typical character of the lesions on the glans of the penis and buccal mucosa.

DISCUSSION

Dr. Busman said the case was interesting from the standpoint of duration.

Dr. Hollander said he did not believe the duration of the disease was as long as the patient stated. The patch on the left hand looked not unlike a lichenification disappearing under roentgen-ray treatment.

Dr. Jacob recalled having seen one case of the hypertrophic form of fourteen years' duration, with an acute outbreak.

Dr. Wertheimer recalled a case which for five years had existed on the buccal mucosa only and did not respond to treatment. At the end of seven years a generalized eruption appeared.

Dr. Crawford agreed with the diagnosis as presented and remarked that it was frequently his experience with this condition that where the eruption was limited in extent, such as a few lesions on the wrists or penis, as in this case, a history of long duration was frequently obtained. He recalled one case in

which the lesions were discoverable only on the buccal mucosa, which persisted for two and a half years and which seemingly were not affected by any local treatment. When these limited lesions occurred on the glabrous skin, they readily disappeared under treatment with the roentgen ray. He could not wholly accept the seventeen years' duration of the hand lesion in this case, which, if true, was a most unusual duration.

ACRODERMATITIS CHRONICA ATROPHICANS. (Herxheimer-Hartmann). Presented by DR. HOLLANDER.

S. P., a man, aged 68, a Jewish real estate agent, presented a symmetrical atrophy of the skin, affecting both legs. The skin was thin, glossy, dark reddish to bluish, smooth and sharply marginated. The condition began seven years before presentation with well defined erythematous patches of eczema about the dorsum of both feet, and gradually involved both legs to the knees.

DISCUSSION

DR. PHILLIPS and DR. WERTHEIMER did not wholly agree with the diagnosis as presented. They felt that the superficial veins, usually pronounced in this condition, were absent, and that the epidermal surface was not sufficiently atrophied to warrant the diagnosis.

A CASE FOR DIAGNOSIS. Presented by DRS. SCHWARTZ and BUSMAN.

Mr. W. J. M., aged 34, a plumber, had presented for the past three years several small annular erythematosquamous lesions over the right cheek, neck and forehead. The individual lesions were slightly infiltrated, some showing a slight central atrophy, but no definite follicular dilatation. The patient gave a history of a penile lesion nine years before presentation, but the Wassermann reaction at the time of presentation was negative.

DISCUSSION

It was the consensus of opinion that the condition was a lupus erythematosus.

GRANULOMA OF UNDETERMINED ORIGIN. Presented by DRS. GUY and JACOB.

W. B., a colored janitor, aged 34, about fourteen years before presentation noticed a small nodule near the right side of the anus. This ruptured, and a mass formed which gradually spread to the present size. When seen the patient showed an inflammatory indurated mass about 15 cm by 6 cm. The center, about 10 cm. by 5 cm., was red, indurated and somewhat moist. The edges were hard nodular and pigmented. The entire mass was located on the right side, there being a slight involvement of the left side. It extended over the perineum. Biopsy showed chronic inflammation, the exudation being rich in plasma cells. There were some curious old hemorrhages to be seen in the section. It was not typical of any particular condition. Blood for the Wassermann test had been taken.

DISCUSSION

DR. HOLLANDER said the appearance was that of a malignant growth on a syphilitic base, but the question of granuloma inguinale should be considered.

DR. BEINHAUER said he considered the condition tuberculosis, and he would like to know whether at any time a fissure had been present.

Dr. Busman said he considered it either tuberculosis or blastomycosis, favoring the latter diagnosis in spite of the absence of pus.

Dr. Crawford said that the rectum should be inspected for a lesion. He thought that tuberculosis was the most likely diagnosis and that a tuberculosis ulcerosa of the anal orifice was present. The marked palm-sized infiltration of the right buttock was probably a lymphatic extension of the process producing what was probably a scrofulous gumma, which eventually would break down. The histologic report of many plasma cells seemed to support this view. The rugose border of the infiltration was composed of nodules, which he believed were tuberculous gummas.

Ichthyosis Hystrix. Presented by Dr. Hollander.

A boy, aged 3, had presented intermittently since 3 months of age symmetrical brownish to blackish rugous and horny patches affecting the hands, arms, axillary folds, feet, legs and the back of the neck, the intervening skin being normal. There were no subjective symptoms, the disease clearing up under treatment.

DISCUSSION

Dr. Jacob said he had seen the case about a year ago, at which time it had cleared up under treatment with strong salicylic acid paste, and in the hope of preventing recurrences the roentgen-ray was applied. As he recalled the condition, it seemed to be about the same as when he saw it first.

Dr. Phillips said he was inclined to think it nevoid in character.

Dr. Busman said he did not think it was an ichthyosis as there was too much involvement of the extremities.

Dr. Hollander said he did not believe that the condition was a nevus because in two days under treatment with starch and glycerin applications it would entirely disappear.

Dr. Crawford said he considered it a symmetrical keratotic nevus involving all of the extremities, including the palms and soles. The keratosis in the flexural surfaces and at the axillary folds was almost hystriciforme in character and was easily removed by keratolytic treatment. He felt it could be called an itchthyosis hystrix but he did not favor this term, owing to the normal character of the skin of the trunk.

Erythema Multiforme. Presented by Drs. Schwartz and Busman.

Mr. H. S., aged 39, a huckster, had numerous flaccid bullae of the oral mucous membranes, together with considerable erythema and maceration of the remaining oral surface. There were also a few unruptured and several ruptured crusted lesions over the elbows, knees, hands and feet. This attack had been present about two weeks, associated with rheumatic pains, and was responding quite rapidly to internal administration of salicylates. The patient stated that he had had one attack of a similar nature of two weeks' duration about one year before.

DISCUSSION

Dr. Beinhauer said he thought that with the presence of the mouth lesions pemphigus would have to be ruled out.

Multiple Superficial Epitheliomas. Presented by Dr. Beinhauer.

Mr. R. S., aged 60, presented on the middle lumbar region an irregularly oval patch, rose red, scaly, with a central atrophy and an advancing sharp, pearly,

slightly rolled out border. Smaller lesions similar in character were seen on the back and over the left chest. At times the lesions were pruritic. The condition started four years ago (the oldest one), gradually spreading peripherally and healing centrally, other lesions appearing one and a half years and one year before presentation, respectively.

DISCUSSION

Dr. Crawford said he considered this case one of erythematoid benign epithelioma, which Graham Little described in a recent issue of the *British Journal of Dermatology*. The lesions were very dry and erythematous and had the narrow, pearly edge and slightly depressed erythematous enclosure described by Dr. Little. Most of Dr. Little's patients were women, whereas this patient was a man.

Dr. Wertheimer said this was an unusual case because of the redness and scaling associated with the rolled pearly border.

Dr. Beinhauer said that in spite of the various treatments the patient had received, the lesions persisted.

H. G. Wertheimer, M.D., Secretary.

Book Reviews

HANDBUCH DER SERODIAGNOSE DER SYPHILIS. By CARL BRUCK, Chief of the Dermatological Department of the Altona City Hospital. Collaborators, V. Kafka, E. Jacobsthal and J. Zeissler. Second revised and enlarged edition, with 46 illustrations, some of them in color. One volume. Pp. 546. Berlin: Julius Springer, 1924.

The introduction explains this as a second edition of Bruck's work on serodiagnosis; but as the first edition was published in 1909, the present work, considering the immense expansion of the literature of the complement-binding reaction and the many new tests devised since then, is more accurately a new book. The introductory chapter dealing with the history of the research which led up to the discovery of the reaction is of great interest, especially the statement giving Neisser credit for making the first suggestion that the complement-binding reaction should be applied to Syphilis. The chapter ends with the statement that "The most important factor in the reliability of the Wassermann-Neisser-Bruck reaction is always the sense of responsibility, the accuracy and trustworthiness of the technician." Bruck writes on the theoretic and experimental basis for the test and then discusses its specificity and diagnostic value. J. Zeissler writes on the technic, favoring the modification of Kaup with added fixation in the ice-water bath, a suggestion of Zeissler. Jacobsthal describes and discusses the precipitation tests. Kafka describes the tests applied to the spinal fluid and discusses their diagnostic value. He also has a final short chapter on the luetin test. The book is one of great value to the serologist and to the clinician who is interested in his serologic aids to diagnosis. The bibliography is excellent, including the American literature, although it is to be regretted that the end of Kolmer's series of papers could not have been included.

LECTURES ON ENDOCRINOLOGY. By WALTER TIMME, M.D., Attending Neurologist, the Neurological Institute, New York. Price, $1.50. Pp. 123, with 27 illustrations. New York, Paul. B. Hoeber & Co., Inc.

In these lectures, Timme has given a valuable summary of what is known of the active secretions of the ductless glands. It is a scientific conservative statement with a considerable bibliography and presents in available, concise form much knowledge of this difficult subject.

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